Washington State

Money Follows the Person Operational Protocol Template

OPERATIONAL PROTOCOL VERSION 1.9

GRANT 1LICMS300141-01-28

May 2026

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Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1053. The time required to amend or newly develop the Operational Protocol is estimated to average 42 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. The time required to complete an annual update of the Operational Protocol is estimated to average 16 hours per response. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

HOW TO USE THE MONEY FOLLOWS THE PERSON OPERATIONAL PROTOCOL TEMPLATE

Purpose

The Operational Protocol (OP) is the operational guide that outlines the Demonstration and addresses how the state or territory will meet the objectives of the Money Follows the Person (MFP) Demonstration. The OP describes how the state or territory will operationalize processes to ensure that the state or territory's Demonstration is equipped with the tools, infrastructure, systems, and policies to make MFP Demonstration goals and initiatives successful.

The state or territory must review and amend the OP every three years, or more frequently as needed, in response to changes in (1) federal, state, or territory law, regulation, or policy impacting MFP eligibility, enrollment, or program operations; and (2) MFP operations, inclusive of changes to any of the required MFP OP elements. Refer to MFP Program Terms and Conditions (PTC) 36 for specific requirements around amending the OP.

While the OP describes "how" the state or territory operates the MFP program, "what" the state or territory plans to do to advance MFP and Medicaid home and community-based services (HCBS) is included in the state or territory's unique MFP Work Plan. Reporting on progress is included in the state or territory's Semi-Annual Progress Report (SAR).

Instructions

The OP template consists of 13 sections. Section A is an overview of the state or territory's MFP Demonstration; sections B through M are the required operational elements of the state or territory's MFP Demonstration. Each section contains prompts for information that are labeled by section and prompt number order (for example, section A.1, prompt A.1.1). The state or territory is required to respond to prompts in each section. Each prompt provides:

- Guidance on how to insert information
- Displays and tools for formatting and inserting information:
  - **Text response boxes.** Information may be entered in multiple lines of text and, where applicable, an external document may be uploaded into a text box.
  - **Table shells.** Table shells display the layout of tables without the information or data. Some table shells contain example entries in red text. Table shell rows may be added if needed. Table shells titled "Example Table" can be modified.
  - **Checkboxes.** Checkboxes are displayed as a checklist in which to place a checkmark to make a selection.

The yellow line at left indicates instructional text and is followed either by a text response box, checkbox, or a table shell.

A few tips for entering information

- Text insertions must be clear, concise, and consistent.
- Directly address each prompt.
- Use the "Other Information" text box when additional information is necessary to further support, explain, or justify a response to a prompt.
- Limit text responses to no more than three pages.

- Use bullet points, tables, flow charts, and diagrams to help break up long sections of text and to briefly summarize information.
- Use preferred terms and spell out first use of acronyms.
- Do not leave prompts blank. Enter “Not Applicable” for OP prompts that are not relevant to the state or territory’s MFP program.

Using hyperlinks and embedding documents

- Use hyperlinks to link to external documents that are relevant to the MFP program, including MFP marketing and educational materials, service-related documents such as assessments and program checklists, and information contained on external websites.
- Hyperlinks must be documented in Appendix A.1 of the OP.
- If you are embedding external documents within the template, follow these instructions and select “Display as icon.” This Word feature allows documents to be embedded as clickable icons and may be a preferable alternative to pasting long documents in the appendix or hyperlinking to a document.
- Accessibility features can be maintained by assigning alt text to the icons representing embedded objects.

Before submitting the OP, complete the following three steps:

1. Ensure that all hyperlinks work.
2. Update the contents of the MFP OP template above by right-clicking anywhere within the field and selecting “Update field.” This will automatically update the page numbers in the contents list.
3. If amending or updating the OP, complete the change log.

Change log

If amending or updating the OP, complete the change log by inserting entries into Table 1. The first two lines of the table provide examples of how to populate the change log.

Table 1. Change log

Section	Prompt	Date of OP submission	Changes made since last revision of OP
All Sections		7/1/2025	Revised Administration name to reflect organizational change from Aging and Long-Term Administration (ALTSA) and Developmental Disabilities Administration (DDA) to Home and Community Living Administration (HCLA). Division of Home and Community Services (HCS) and Developmental Disabilities Community Services (DDA) support the targeted populations within the MFP Demonstration.
		4/30/2026	Revised Divisions under HCLA as Developmental Disabilities Community Services has reverted to its own Administration, Developmental Disabilities Administration (DDA).
B	B.1		Updated Organizational Structure visual to include the changes within the Home and Community Living Administration.
		4/30/2026	Updated Organizational Structure visual to include the changes to Developmental Disabilities Administration.
	B.2		Added detailed description of projected and current MFP Funded positions to include the Project Director and DQA positions. These descriptions are in alignment with existing Budget Personnel descriptions, and positions will be included in the CY2026 Supplemental Budget request.
C	C.1.2		Specified steps taken to verify MFP eligibility for individuals transitioning from an IMD.
E	E.3.1		Corrected supplemental service name from Budget Counseling to Credit Counseling Replaced imbedded Supplemental Service Descriptions PDF
F	F.1.1. F.3		Clarified the transition coordination process for each target population Added details outlining how the state verifies and documents MFP-qualified residence types
H	H.1		Detailed Washington's approach to improving the quality of TMSIS data
I	I.1		Replaced the link with an embedded document of Appendix H: QMS for 1915 (c)

SECTION A. MFP PROGRAM OVERVIEW

This section briefly describes how the state or territory's MFP Demonstration is designed to meet unique state or territory long-term services and supports (LTSS) system reform efforts to increase the use of HCBS, rather than institutional LTSS. Use the prompts in this section to report on the state or territory's LTSS system assessment and gap analysis and to identify the state or territory's MFP Demonstration target population and geographic area(s) of service.

A.1. State or territory system and gap analysis

A.1.1. Summary of state or territory LTSS system and gap analysis

The summary must address these components:

- Identify LTSS population needs
- Identify geographic area(s) of need
- Identify ways the state or territory can test new approaches and flexibilities in its Medicaid programs to strengthen HCBS through the MFP Demonstration
- Identify ways to provide opportunities to furnish MFP Demonstration services in a more equitable manner
- Identify and determine measurable, attainable, and timely MFP Demonstration goals and outcomes

Washington State has a well-developed long-term care system, with more than ninety percent of its services and supports provided in home and community settings. Even with our mature network of community services and many years of MFP demonstration provision, we continue to identify ways to address barriers to successfully transitioning individuals out of institutions. Focusing efforts on increasing HCBS service capacity in rural communities to include tribal communities, increasing availability of accessible and affordable housing, reducing challenges with direct care workforce, onboarding and ongoing education and development to strengthen person-centered practices, and decreasing gaps in knowledge related to the services available and how they can be combined to support an individual's transition and sustainability within a community setting.

In Washington (WA) nursing homes, intensive and successful efforts are made to transition individuals within the first month to two months of their stay. However, if for any reason the length of stay is prolonged, barriers to moving back into the community become considerably greater. Ongoing MFP services will continue to provide the Home and Community Living Administration (HCLA) opportunities to offer additional services and supports to those currently available in existing 1915(c) waivers and state plans, in hopes that they may be key to helping residents who choose to move out of these institutional settings. Within the Developmental Disabilities Administration, increasing numbers of individuals are requesting to move from the State operated Residential Habilitation Centers (RHCs) to the community. In addition, the philosophy in Washington State has changed over the past fifteen years, with long-term institutional admissions often being viewed as a last resort. Instead, these settings are now focusing on providing shorter-term, habilitative, rehabilitative and health care services. Individuals with serious and persistent mental illness also face significant barriers in terms of having the support necessary to move to the community after long institutional stays.

Washington State's MFP demonstration, entitled Roads to Community Living (RCL), builds upon our experience designing successful statewide community-based service systems. RCL uses state and federal funds to transition as many individuals as possible who are eligible to receive services under the demonstration. Our vision for this demonstration project is twofold. First, we plan to support the

demonstration participants who choose to move from institutional settings to the community and do this in a way that is person-centered and responsive to their individual needs. While the person is still in the institution, a stable and sustainable discharge plan that addresses the person's goals and needs will be established. This emphasis on person-centered planning in RCL will support more widespread use of self-direction and consumer empowerment – both essential elements for continued rebalancing of the long-term care system.

Second, we expect to identify services and supports that may be modified or added to existing programs to help individuals in the future bypass some of the existing barriers to institutional transitions. We do this by building and strengthening our relationships with our stakeholders to elicit and respond to public questions, concerns and comments regarding service delivery and case management approaches. Washington's long-term care services are funded largely through legislative appropriations matched by federal Medicaid monies through the state plan or waivers. Medicaid payment continues to be tied to rigid service definitions required in traditional HCBS waivers and state plans. The billing process necessary to support maximum Medicaid federal match is time consuming and restrictive for state staff and providers alike. This interferes with true individual planning for unique one-time needs. Consumer and provider feedback for this project has very clearly pointed out that the parameters by which these services are offered, and their delivery mechanisms, have created barriers to HCBS access. This highlights the need for a more streamlined, cohesive offering of services and supports which are more easily accessible to both consumers and those coordinating or providing their care. It is our goal that this demonstration will continue to move the Washington State long term services and supports system in this direction. At a minimum of a quarterly basis, the MFP Project Director is consulting with other HCBS Programmatic staff to discuss successful approaches to MFP specific service roll outs and delivery to identify opportunities or challenges to add or include these services into a state plan or waiver program. A workplan, timeline, and shared responsibilities are then outlined for incorporation.

The RCL demonstration project is managed by the Department of Social and Health Services (DSHS), Home and Community Living Administration (HCLA) and operated by the Developmental Disabilities Administration (DDA) and Home and Community Services (HCS) divisions. HCS primarily serves older adults, individuals with physical disabilities, and individuals with behavioral health needs who receive services in long term care settings. DDA serves individuals with intellectual and/or developmental disabilities. RCL is designed to assist people who have been in a Nursing Facility, Hospital or DDA Residential Habilitation Center for 60 days or longer who want to move to their own homes, apartments, Adult Family Homes or other residential settings. Participants must receive Medicaid benefits for inpatient services for a minimum of one day to become eligible to participate in the RCL demonstration.

A.2. Service areas and target groups of the MFP program

A.2.1. Service areas

Specify the service area(s) in which the MFP Demonstration operates.

☒ State or territory-wide

☐ If not state or territory-wide, indicate specific jurisdictions:

Not Applicable, as this is a statewide program.

A.2.2. Target groups

Complete Table A.2.2 to indicate the MFP target population(s) included in the state or territory's Demonstration and indicate the corresponding state or territory operating agency administering Medicaid

HCBS. Please note that target groups falling into the "Other" category must be defined here and throughout the OP.

Table A.2.2. MFP target population groups

Select all that apply	Target group of eligible individuals	State or territory operating agency
☒	Older adults	Home and Community Living Administration, Home and Community Services division
☒	Individuals with physical disabilities (PD)	Home and Community Living Administration, Home and Community Services division
☒	Individuals with intellectual and developmental disabilities (I/DD)	Developmental Disabilities Administration
☒	Individuals with mental health and substance use disorders (MH/SUD)	Home and Community Living Administration, Home and Community Services division
☐	Other, please specify (e.g., HIV/AIDS, brain injury)	

Describe reasons for targeting certain MFP populations. Include geographic strategies, considerations specific to rural areas, provider network considerations, and alignment with state or territory Olmstead plans and rebalancing strategies.

Across the Department of Social and Health Services, we focus on key service and foundational priorities to guide our Strategic Plan. Two divisions of HCLA within DSHS are responsible to serve the above MFP target population groups statewide. This section is organized according to these Administrations.

The Home and Community Services division is responsible for Washington State's nationally recognized system of long-term services and supports serving older adults and people with disabilities. The Strategic Plan for Home and Community Living Administration identifies the following goals:

1. Champion services and supports that increase Access, Choice & Integration.
2. Honor Independence, Rights, Health & Safety for vulnerable adults living in home- and community-based settings.
3. Optimize Partnerships & Lived Experiences.
4. Improve Quality, Accountability and Responsiveness.
5. Cultivate Strong Workforce and Implement Technology Supports.
6. Empower Staff Belonging, Engagement, Innovation and Wellbeing.

The Developmental Disabilities Administration provides a coordinated service delivery system for people with developmental disabilities. The Strategic Plan for Development Disabilities Administration identifies the following goals:

1. Support individuals with developmental disabilities to live and thrive in the communities and settings they choose.
2. Expand accessibility, services, capacity, and increase utilization of supports & services for individuals with developmental disabilities.
3. Enhance DDA's comprehensive quality management system to ensure we are meeting the needs of our clients and workforce while complying with federal, state and program requirements.
4. Advance the comprehensive structural and behavioral transformation to become a proactive-equity and anti-racist agency.

Home and Community Living Administration partners with the Behavioral Health and Habilitation Administration to coordinate in providing services to older adults, adults with physical disabilities and those individuals with intellectual/developmental disabilities who also have behavioral health needs. As part of our work in behavioral health transformation in Washington, we have added contracts that provide

specialized supports within community residential settings and skilled nursing facilities. In addition, we are increasing our number of supportive housing providers and wraparound supports to meet the needs of people who desire to live independently in their community. We provide additional training and support to community care providers who serve people with complex functional and behavioral support needs.

Washington is among the nation's leaders in rebalancing away from an over-reliance on institutional settings and supporting individual and family preferences to be served in home and community-based settings. The Washington State Legislature recognized the desire of most people to maintain as much independence as possible and to receive services in their own homes and in home-like residential settings that are in local communities. As a result, the Legislature directed DSHS to expand community options that provide opportunities for people to divert and relocate from nursing homes, hospital and residential habilitation settings. MFP continues to be in alignment with the WA State Olmstead Plan.

A.3. Other information

If needed, provide other information regarding the state or territory's service area(s), target populations, or reporting that is not addressed elsewhere in the template.

Please see Appendix for State Map of Medicaid Certified Nursing Facility Beds.

DDA Supported Living community program locator: Supported Living Program Locator - WA State

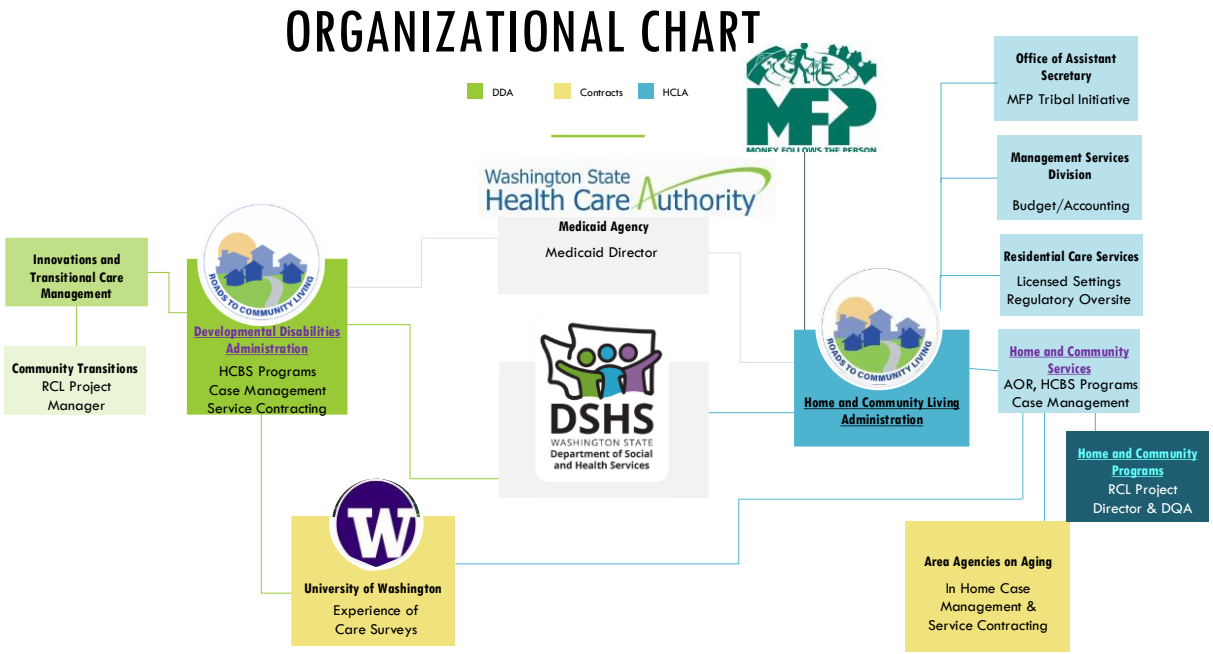
SECTION B. PROJECT ADMINISTRATION

B.1. Administrative structure

B.1.1. Organizational chart

Provide an organizational chart that shows the entity responsible for the management of the MFP cooperative agreement and the Authorized Organizational Representative;[1] how the management entity relates to all other departments, agencies, and service systems providing HCBS to MFP participants; and the relationship of the organizational structure to the state or territory Medicaid agency and state or territory Medicaid director (SMD).

Upload the organizational chart into either the appendix or text box or provide an external link.



MFP Project Director and MFP Data and Quality Analyst positions reside within the Office of Home and Community Programs within the Home and Community Services Division. The Authorized Organizational Representative is the Director of Home and Community Services. The Office of Assistant Secretary, Home and Community Services, Residential Care Services, and Management Services Divisions all have operational roles with WA's MFP program within the Home and Community Living Administration which is an administration within the Department of Social and Health Services. For those MFP participants exiting I/DD institutional settings, the Developmental Disabilities Administration division (DDA) provides HCBS and MFP transition support to this population as part of HCLA. The Home and Community Living Administration has a cooperative agreement with the Health Care Authority (HCA) to administer and operate long term services and supports. HCA is the Medicaid Agency and employs the State Medicaid Director (SMD).

[1] The Authorized Organizational Representative is defined in the MFP Demonstration Program Terms and Conditions (PTC 25).

B.1.2. Administrative structure

Describe how the state or territory will structure the administration of the MFP program, including how roles and responsibilities will be coordinated across state or territory operating agencies and managed care plans (MCP) (if applicable). Clearly indicate how the organizational and structural administration will function to implement, operate, and monitor the OP elements of the Demonstration.

Example Table B.1.2. Administrative structure

Administrative entity (state/territory, other government entity, MCP or contractor/consultant)	OP element(s)	MFP role and key responsibilities (how the entity will implement, operate, or monitor the OP element)	Formal commitments (for example, Memorandum of Understanding)
Home and Community Living Administration (HCLA), Home and Community Services division	Project Administration, Recruitment Enrollment Outreach and Education/Stakeholder engagement/Benefits and Services/Transitions and Housing Services/Self-Direction and Informal Caregiving/Reporting/Quality Measurement Assurance and Monitoring/Continuity of Care Post-Demonstration/ Public Health Emergencies	Serving Older Adults, Disabled Adults and those with Behavioral Health Disorders in need of LTSS. Provides regulatory oversight over licensed LTSS residential settings, supports budgetary, accounting and fiscal reporting.	Cooperative Agreement with CMS for MFP.
Home and Community Living Administration (HCLA) Office of the Assistant Secretary (OAS) division	Tribal Initiative	The MFP Tribal Initiative is also managed by OAS.	Cooperative Agreement with CMS for MFP.
Developmental Disabilities Administration (DDA)	Recruitment Enrollment Outreach and Education/Stakeholder Engagement/Benefits and Services/Quality Measurement Assurance and Monitoring/Continuity of Care Post-Demonstration	Serving those with I/DD and LTSS needs.	Cooperative Agreement with CMS for MFP.
Health Care Authority	Benefits and Services	Provides Medical Benefits (called Apple Health Benefits)	Cooperative Agreement with HCLA for LTSS
Area Agencies on Aging	Benefits and Services/Transitions and Housing Services/Self-Direction and Informal Caregiving/Quality Measurement Assurance and Monitoring/Continuity of Care Post-Demonstration	Procures, manages and monitors most Client Services Contracts and maintains HCBS network adequacy. Manages most HCBS client services contract procurement and network capacity. Provides case management activities for in-home clients.	Contract with HCS
University of Washington	Quality Measurement Assurance and Monitoring	This university is contracted to conduct the HCBS Quality Measure set element of the NCI-AD and NCI-IDD experience of care survey activities.	Contract/Interlocal Datashare Agreement with DDA and with HCS

The Home and Community Living Administration is the operating agency for Long Term Services and Supports to include Home and Community Based Services delivery for those who are Aged, Blind and physically disabled, which is managed by the Home and Community Services division. The Developmental Disabilities Administration provides HCBS services to those with developmental or intellectual disabilities.

B.2. Staffing

B.2.1. Project director and data and quality analyst

Upload the job description and performance evaluation criteria for these positions into the appendix or provide an external link.

The MFP Project Director plays a vital leadership role in overseeing the implementation and operation of Washington State's Roads to Community Living (RCL) demonstration project. This is a full-time position tasked with planning, organizing, and managing all aspects of the demonstration, with a particular focus on ensuring meaningful participant and stakeholder involvement in the design, implementation, and evaluation of project activities.

Key responsibilities include coordinating and organizing multi-agency efforts, developing partnerships across both public and private sectors, supporting outreach and resource development, and directing data collection and analysis functions integral to successful project execution. The Director also provides strategic guidance to senior leadership within Home and Community Services (HCS) on rebalancing initiatives and RCL-related policy, particularly regarding transitions from nursing facilities to Home and Community-Based Services (HCBS), utilizing state plans, Medicaid waivers, and MFP protocols.

Importantly, this position supports broader statewide responsibilities, most notably the development and oversight of nursing facility case management and relocation policies and procedures—which fall outside the scope of MFP-funded activities but are significantly informed by MFP funded initiatives. Due to the comprehensive nature of these duties and their alignment with system-level functions, the position is not supported by MFP Federal Grant funds, but through other HCBS Medicaid funding. The project director position receives an annual evaluation by the Office Chief of the Community Transitions Office which is reviewed and signed by the AOR.

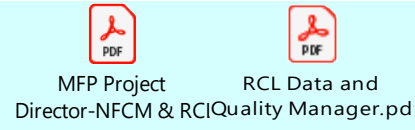
The Data and Quality Analyst (also referred to as the Data and Quality Manager) plays a critical role in coordinating and managing data systems for the Roads to Community Living (RCL) demonstration project. Reporting directly to the Project Director and evaluated annually, this position collaborates closely with data technology teams, MFP Enrollment Specialists, Home and Community Services (HCS) staff, and Quality Assurance to develop, refine, and maintain data collection and reporting processes that enhance the integrity and utility of data related to transitions from nursing facilities and hospitals to community-based settings. These data insights directly inform policy and procedural recommendations aimed at improving transition outcomes.

In addition to overseeing data quality, the Data and Quality Manager supports the development and refinement of Money Follows the Person (MFP) provider contracts, facilitates contract monitoring, and contributes to the consistent determination of rates for transition services. In Washington State, Area Agencies on Aging (AAAs) traditionally manage community contracts, but have not historically handled contracts for services provided in nursing facilities to support Pre-Transition activities. As a result, the responsibility of onboarding new providers has shifted to HCS, creating systemic challenges that this position helps to address.

In collaboration with the Enrollment Specialists, the Data and Quality Manager evaluates contract acquisition strategies, recommends best practices for rate development, and identifies solutions to

streamline operations. The role also supports strategic use of RCL Reinvestment funds to maximize impact and improve provider engagement and service delivery.

Both position descriptions are inserted here:



B.2.2. Other project staff

Complete Example Table B.2.2 for all non-contract positions. Describe the MFP role, responsibilities, and relevant OP element(s) for each position in the last column on the table. Responses for the last column may be provided as table text, embedded documents, external links, or text indicating where the response has been added in the appendix. The relevant OP element(s) for each role are the MFP program components (as defined by the major section headers of this document; for instance, D. Community Engagement, E. Benefits and Services, and H. Reporting) on which the staff person in that position will work.

Example Table B.2.2. MFP Demonstration staff

Number and position title	Percent of full-time equivalent	Administrative or service position (if service position, indicate whether Demonstration or supplemental)	Indicate if non-contract or contract/consultant position	MFP role, responsibilities, and relevant OP element(s)
(3) RCL Enrollment Specialists	100%	Administrative-Home and Community Services	Non-Contract	These (3) positions manage the administrative elements of MFP enrollments, evaluate, and assess the effectiveness of RCL relocation activities of Older Adults and Disabled Adults to identify best practices and areas of learning that will influence policy development, staff and provider training, resource development, and regional practice or relocating individuals with complex needs from Nursing Facilities to community-based settings. These positions will work with the HCS and AAA case managers to identify regional and statewide resource needs and support the development and utilization of contracted service providers to meet these needs. As RCL regional enrollment specialists, they will also assist with creating and facilitating field training and contract monitoring as directed by the Data and Quality Manager.
Technology Support Services Specialist	100%	Administrative-Home and	Non-Contract	This position supports MFP participants by increasing adoption and effective use of assistive devices

Number and position title	Percent of full-time equivalent	Administrative or service position (if service position, indicate whether Demonstration or supplemental)	Indicate if non-contract or contract/consultant position	MFP role, responsibilities, and relevant OP element(s)
		Community Services		and technology support services. The specialist evaluates RCL relocation activities, informs policy and training, and works with regional staff to identify and address statewide resource needs. The role also supports digital training platform development and contract monitoring with the goal of increased integration of technology support services into successful community transitions.
RCL Enrollment Hospital Specialist	100%	Administrative-Home and Community Services	Non-Contract	This statewide position is essential to managing the administrative and strategic elements of MFP enrollments, specifically for Older Adults, Disabled Adults, and individuals with Behavioral Health needs transitioning from hospital settings to community-based care. The position leverages expertise and establishes relationships with hospital operators across Washington to foster collaboration, facilitate timely discharges, and ensure continuity of care. By evaluating the effectiveness of Roads to Community Living (RCL) relocation activities and identifying best practices, this position's success depends on its ability to influence system-level improvements by leveraging statewide relationships and expertise in navigating hospital-based care environments. Acting as a trusted liaison, the specialist will partner with hospital case managers, RCL Enrollment Specialists, and healthcare institutions to close service gaps, strengthen communication, and support consistent practice statewide. This role also contributes to training development and facilitation in collaboration with RCL staff, with the goal of increasing enrollment and successful transitions out of Hospitals.
RCL Nurse Specialist	100%	Administrative-Home and	Non-Contract	This RCL Nurse Specialist brings clinical insight, care coordination experience, and systems-level thinking that are critical to safe,

Number and position title	Percent of full-time equivalent	Administrative or service position (if service position, indicate whether Demonstration or supplemental)	Indicate if non-contract or contract/consultant position	MFP role, responsibilities, and relevant OP element(s)
		Community Services		person-centered, and cost-effective transitions. The position provides high-level consultation and policy development in collaboration with RCL Enrollment Specialists, offering clinical guidance that ensures services align with medical needs, client preferences, and program goals. It will also facilitate cross-agency collaboration with professionals across DSHS, HCS, DDA, HCA, and external healthcare partners to problem-solve barriers and coordinate seamless care delivery. By incorporating clinical oversight into RCL transitions, this role strengthens the program's ability to serve individuals with complex medical or behavioral health needs, reducing hospital readmissions, improving outcomes, and promoting sustainable community living. The Nurse Specialist will also contribute to training and capacity-building efforts, equipping staff and providers with the knowledge needed to support high-acuity transitions safely and confidently.
(12) Home and Community Services Case Managers	50%	Administrative-Home and Community Services	Non-Contract	These advanced-level case managers support transitions from nursing facilities to community-based settings, tailored to each client's preferences. Responsibilities include conducting outreach, performing functional assessments, authorizing supportive transition and community-based services in alignment with a person-centered care plan. In accordance with our approved Public Assistance Cost Allocation Plan, field staff costs are prorated based on caseload data, meaning funding from the MFP grant fluctuates according to the number of transitions. Because these positions often manage multiple facilities and clients, strong organizational and leadership skills are essential.
(1) Tribal Initiative Program Manager	100%	Administrative-Office of Assistant Secretary	Non-Contract	This position plays a critical role in bridging Washington's long-term services and supports (LTSS)

Number and position title	Percent of full-time equivalent	Administrative or service position (if service position, indicate whether Demonstration or supplemental)	Indicate if non-contract or contract/consultant position	MFP role, responsibilities, and relevant OP element(s)
				programs with Tribal communities statewide. Its primary goal is to expand access to locally adapted home and community-based services, reduce institutional placements, and strengthen government-to-government relationships—all in alignment with CMS objectives. 100% of this position's time is dedicated to MFP-specific Tribal outreach under the Money Follows the Person Tribal Initiative (MFPTI). The role serves as a liaison between Tribal nations and state partners—including evidence-based program managers, trainers, resource development, and workforce teams—to enhance care coordination, resource access, and training opportunities reimbursable by CMS. While focused on Tribal communities, the work also benefits the broader LTSS system by promoting sustainability and localization. The position acknowledges the importance of non-Tribal partners and actively works to close knowledge gaps between state and county agencies and Tribal governments. Beyond coordination, the role is deeply rooted in relationship-building—establishing trust and long-term partnerships with American Indian/Alaska Native communities. It fosters collaboration among Tribal entities, state agencies, and community organizations to align services with traditional systems of care. Identified gaps—such as limited awareness of state services, institutional distrust, and lack of locally-relevant appropriate care—directly hinder Tribal members' access to MFP services. These gaps inform policy and practice recommendations that aim to:

Number and position title	Percent of full-time equivalent	Administrative or service position (if service position, indicate whether Demonstration or supplemental)	Indicate if non-contract or contract/consultant position	MFP role, responsibilities, and relevant OP element(s)
				• Improve outreach and education about available LTSS and MFP services. • Address systemic barriers rooted in historical and institutional challenges. • Ensure Tribal perspectives are integrated into service design and policy development. In addition to outreach, the position supports MFPTI implementation through contract management, event and training planning, and participation in state-level workgroups. It elevates Tribal values while advancing shared CMS priorities—keeping Elders and individuals with disabilities in their communities, receiving care they choose.
Communications and Marketing Manager	100%	Administrative-Office of Assistant Secretary	Non-Contract	This position leads targeted outreach and communications strategies aimed at supporting the Money Follows the Person Tribal Initiative (MFP TI), celebrating Roads to Community Living (RCL) Transition Success stories, and enhancing workforce development recruitment for direct caregiving roles. This position leads professional video creation and targeted marketing campaigns that promote culturally respectful engagement and elevate public awareness. The position ensures consistent, strategic messaging to attract caregivers, highlight program impact, and builds trust with tribal partners, strengthening statewide access to community-based care.
Service Experience Team/Direct Care Workforce Collaborative Project Manager	100%	Administrative-Home and Community Services	Non-Contract	This position is fully dedicated to the Money Follows the Person (MFP) Demonstration. The incumbent spends 100% of their time on outreach, engagement, and follow-up with individuals who have been enrolled in MFP, accessing MFP services and supports, or their caregivers. The position also collaborates with other teams through regular communication and joint

Number and position title	Percent of full-time equivalent	Administrative or service position (if service position, indicate whether Demonstration or supplemental)	Indicate if non-contract or contract/consultant position	MFP role, responsibilities, and relevant OP element(s)
				strategy sessions to align efforts and avoid duplication. All client and caregiver feedback reviewed by this position originates from MFP participants and their caregivers. Because Medicaid Home and Community-Based Services (HCBS) recipients often transition across multiple programs during their tenure with the Administration, the feedback collected and analyzed consistently reflects the experiences of individuals connected to MFP. The position applies Human-Centered Design (HCD) principles to engage directly with clients and caregivers, facilitate collaborative problem solving, and embed participant perspectives into program design. This approach ensures service delivery is respectful, responsive, and aligned with client goals for independence and quality of life.
Workforce Training Program Manager	100%	Administrative-Developmental Disabilities Administration	Non-Contract	The Workforce Training Program Manager is fully dedicated to the Money Follows the Person (MFP) Demonstration, with 100% of the position's time allocable to MFP-related activities. This position ensures that MFP qualified residential providers serving MFP participants are fully staffed to meet training, certification, and compliance requirements. Recruitment emphasizes the necessity of transitioning individuals out of institutions into community settings of their choice, with targeted recruitment occurring in geographic areas where need is greatest. For specialized staffing needs, providers work directly with the Program Manager to identify and recruit qualified staff. This role focuses specifically on recruiting staff to serve MFP participants with intellectual and developmental disabilities (I/DD) and behavioral needs, requiring advanced expertise in residential service requirements. By ensuring adequate staffing capacity, this position

Number and position title	Percent of full-time equivalent	Administrative or service position (if service position, indicate whether Demonstration or supplemental)	Indicate if non-contract or contract/consultant position	MFP role, responsibilities, and relevant OP element(s)
				prevents delays in MFP transitions, reduces risk of disrupted placements, and strengthens the infrastructure needed for sustainable community living.
Community Transitions Quality Improvement Specialist	100%	Administrative-Developmental Disabilities Administration	Non-Contract	The Community Transitions Quality Improvement Specialist is fully dedicated to the Money Follows the Person (MFP) Demonstration, with 100% of the position's time allocable to MFP-related activities. This role oversees quality assurance activities for individuals with intellectual and developmental disabilities (I/DD) who are transitioning from state-operated ICF-IIDs, nursing facilities, hospitals, and other institutional settings into MFP-qualified community residential supports. The Specialist researches barriers to timely and effective transitions, including the root causes of institutionalization for individuals waiting in hospitals or other institutions, and the factors contributing to disruptions in community residential services that may force individuals to return to institutional care. Key responsibilities include making recommendations for DDA data collection efforts related to MFP transition timeliness, wait times, and the effectiveness of MFP community-based service delivery. The Specialist reviews processes and procedures to improve transition timelines and reduce re-institutionalization for clients identified as being at risk of MFP service disruption.
RCL Enrollment Specialist (DDA)	100%	Administrative-Developmental Disabilities Administration	Non-Contract	The position is responsible for the strategic coordination, implementation and monitoring of the Money Follows the Person (MFP) Rebalancing Demonstration Grant within DDA. As the primary liaison, this role ensures that individuals with I/DD transitioning from institutional to community-based settings receive person-centered, sustainable, and compliant services. Ensuring key

Number and position title	Percent of full-time equivalent	Administrative or service position (if service position, indicate whether Demonstration or supplemental)	Indicate if non-contract or contract/consultant position	MFP role, responsibilities, and relevant OP element(s)
				supports are in place for people moving from institutions to the community is a major responsibility of this position, including decision-making assistance, timely health care access, affordable housing, and provider training to ensure long-term success. This position ensures thoughtful, individualized transition planning that results in stability and continuity of care. Through collaboration with regional case management staff and stakeholders, the role drives consistent implementation statewide and works to eliminate systemic barriers to timely discharge. Serving as a subject matter expert in MFP-RCL policy and transition planning, the position contributes to both short- and long-term strategic goals. It ensures compliance with CMS requirements while aligning services with legislative goals for person-centered, community-based care.
RCL Transition Communications Program Manager	100%	Administrative-Developmental Disabilities Administration	Non-Contract	This position is responsible for developing and executing communication strategies for DDA to increase awareness and MFP program enrollment. This is accomplished by the production of videos explaining community-based services. The production of referral videos for individuals living in institutions so prospective residential providers can get to know the person in a way that is more effective and efficient than written case files. This position writes, edits, and distributes content for DDA MFP and other related MFP initiatives such as website copy, and brochures and informational publications regarding community-based services. They develop and distribute MFP information to DDA employees through emails, intranet updates, and other channels. This position also organizes and manages events, both internal and external, to promote the DDA organization or its initiatives,

Number and position title	Percent of full-time equivalent	Administrative or service position (if service position, indicate whether Demonstration or supplemental)	Indicate if non-contract or contract/consultant position	MFP role, responsibilities, and relevant OP element(s)
				and ensures consistent messaging and a positive public image for the MFP grant.

B.2.3. In-kind support

Describe positions providing in-kind support (that is, support from non-MFP staff) to the MFP Demonstration. Indicate the percentage of time each individual or position is dedicated to the grant and the roles and responsibilities of each position. Indicate the OP element(s) the positions will support. If a large number of staff provide in-kind support to the MFP Demonstration, describe the staff in general or aggregate terms, such as contracting specialists, fiscal staff, etc.

The Office Chief of Home and Community Program Office (HCS) provides 10% of in-kind support to supervise the director, provides direction for incorporating services into state plans or waivers, and coordinating with stakeholders. This position oversees the Roads to Community Living (RCL)/Nursing Facility Case Management (NFCM) Policy Unit. OP elements include project administration.

The CARE Assessment Program Manager provides 5% in-kind support to develop, refine and implement any CARE Tool modifications and enhancements for case managers using the CARE Tool. OP elements include Benefits and Services and Reporting.

The HCS Waiver and statewide Program Managers (2) provide 5% in kind support to manage HCBS and waivers. These positions submit State Plan Amendments or Waiver amendments as needed. The OP elements include Benefits and Services.

The Rental Assistance Unit Manager and Specialists (4) provide 10% in-kind support to oversee the Short-Term Rental Assistance applications, approvals and payments available under the Project. The OP elements include Transition and Housing Services.

Quality Assurance Specialists (3) provide 10% in-kind support for state evaluation and analysis of the Roads to Community Living program. The OP elements include Quality Measurement Assurance and Monitoring.

A Budget Analyst provides 15% in-kind support for supporting grant expenditure reporting, supplemental budget activities, financial documentation and submissions in the GrantSolutions.gov website. The OP elements include Project Administration.

The DDA Deputy Director of Field Operations and Transitional Care Management provides 5% of in-kind support to supervise the DDA Community Transitions Unit Manager and outreach development specialists. The DDA Community Transitions Unit Manager also provides 50% of in-kind support and supervises the RCL Enrollment Specialist. In addition, this Unit Manager also supervises the RCL Quality Improvement Manager. The DDA RCL Quality Improvement Manager supports the MFP grant 100% with in-kind support. The OP elements include Recruitment, Enrollment, Outreach and Education.

HCS Nursing Facility Case Management FTEs provide 25% of in-kind support to support transitions from nursing facilities to community-based settings. Responsibilities include conducting outreach, performing functional assessments, authorizing supportive transition and community-based services in alignment with a person-centered care plan. The state employs 100 FTE which facilitate over 4000 transitions from Nursing Facilities each year under multiple State Plans, Waivers, State funded service packages and

WA's MFP Program: Roads to Community Living. WA uses the approved Public Assistance Cost Allocation Plan to determine how many of these positions are included in the MFP Admin funding at 50% reimbursement. See table B.2.2 for this description.

B.2.4. Staffing and contract execution timeline

Provide a hiring timeline (start and end date) for non-contract staff. For contract, consultant, or subrecipient positions, provide the contract execution date and expected expiration/end date.

Washington will be adding five positions in July 2025, two of which are summer interns (July-September). All other non-contract positions are filled. There are no contracted individuals directly supporting the management of the grant. Those functions are being performed by state staff as outlined in previous sections of B.2.

DDA does purchase technical assistance from contractors with specialized support, knowledge and expertise in the following areas as needed:

- Providing support to clients with co-occurring I/DD and behavioral health needs who are difficult to serve;
- Assistive Technology necessary to community living;
- Housing modifications and development; and
- Training of providers on supporting clients to transition from institutional living to community living.

This contract will be renewed July 1, 2025, and expires June 30, 2027.

B.3. Billing and reimbursement

B.3.1. Billing and reimbursement procedures

Describe how the state or territory will establish billing and reimbursement procedures to link Medicaid claims to MFP individuals. Include the following:

- Description of MFP identifier codes in the Medicaid Management Information System (MMIS) and if applicable in the state or territory accounting system
- Description of procedures for ensuring against duplication of payment for the Demonstration and Medicaid programs
- If the state or territory operates a managed long-term services and supports (MLTSS) program, description of your state or territory's managed care claiming methodology to determine the portion of the capitation rate that is attributable to qualified HCBS listed in Attachment A of the MFP PTC
- Procedures for fraud control and monitoring

Billing and reimbursement will be managed through the systems currently used for waiver and State plan services. Washington has extensive fraud control and financial monitoring systems in place.

Payment Procedures
Washington uses one payment/billing Medicaid Management Information System (MMIS) called ProviderOne. This payment/billing system is utilized to process claims pertaining to the services provided to HCBS recipients. RCL claims processing will use the same payment processing system as all other waiver and State plan services.

ProviderOne uses Social Service Code sets, which are mapped to a Recipient Aid Category (RAC) for each program. RCL has an assigned specialized Recipient Aide Category. Services for consumers in RCL can only be authorized using RCL RAC and social service codes mapped to the RCL RAC.

The ProviderOne system maintains data on waiver recipients including recipient name, birth date, social security number and an assigned ProviderOne identification number. The recipient data is associated with the provider's name, ProviderOne provider identification number, RAC begin and end dates, unit rate, authorized social service code, amount paid, date paid, etc.

DDA Case Managers, HCLA social service specialists, community nurse consultants and contracted Area Agency on Aging case managers utilize the ProviderOne system to authorize waiver service payments for applicants/recipients meeting financial and service eligibility factors. The authorized service payments correlate with recipient needs identified in the CARE assessment Care Plan.

Within HCS, the Director (the AOR) approved the continuation of our longstanding subsidy payment process for MFP short-term rental assistance in lieu of MMIS. This decision was based on the system's historical operation outside of MMIS and the challenges of paying recurring subsidies under this service payment model. We use the A19 process with specific identifier codes, ensuring subsidy payments are made on the first of the month. The accounting team processes A19 invoices monthly, utilizing programmatic specific accounting codes.

Subsidy payment information (invoice) is received from Spokane Housing Authority (SHA) monthly. Each entry in the invoice is reviewed to detect duplicate or inaccurate payments. Revisions to the invoice are required to be made by SHA if duplicate or incorrect payment amounts are found. Subsidy recipient names are reconciled against HCS' Office of Housing and Employment's (OHAE) internal database and OHAE budget/subsidy recipient list to verify that the designated funding source is correct. The list is verified by the MFP Data and Quality Analyst to confirm MFP eligibility for the month of service. Any subsidy recipients who do not meet MFP eligibility criteria or have utilized the six-month service limit do not receive MFP short-term rental assistance. These individuals are then enrolled in the state-funded rental assistance program for ongoing housing stability and documented in the Consolidated Housing Assistance Information (CHAI) internal database. The MFP short-term rental assistance recipient invoice is sent to accounting staff and paid with MFP accounting codes.

Fraud Control and Monitoring

(a) Requirements concerning the independent audit of provider agencies.

Home Care Agencies are required to have an independent financial audit without findings covering the two-year period prior to contracting. The audit must be conducted by a licensed CPA or a recognized financial firm.

Federal rules are followed for agencies that have non-profit status per the Single Audit Act and OMB CIRCULAR A-133. A single or program specific audit is required for the AAA and other subcontractors who expend more than $750,000 in federal assistance in a year. If the subcontractor is a for-profit organization, it may be a sub recipient, but it will not fall under the OMB CIRCULAR A-133 requirements for a federal single or program-specific audit. In this unique case, the for-profit is monitored annually as follows:

1. By performing a desk review of the vendor's annual audit,
2. By on-site monitoring and completion of the monitoring worksheet. AAAs are required to use the following risk factors to help determine if on-site monitoring should be done:
    a. Frequency of outside audits

b. Prior audit findings
c. Type of Client Services Contract
d. Dollar amount of contract
e. Internal control structure of subcontractor
f. Abnormal frequency of personnel turnover
g. Length of time as a subcontractor
h. History of marginal performance
i. Has not conformed to conditions of previous contracts

3. Review of subcontractor's relevant cost information when contract is renewed. The State Auditor's Office conducts the periodic independent audit of the waiver program as required by the single audit act. The Roads to Community Living Program also was audited by the State Auditor's Office in 2023.

(b) The financial audit program that the State conducts to ensure the integrity of provider billings for Medicaid payment of HCBS services, including the methods, scope and frequency of audits.

Area Agencies on Aging are responsible for monitoring Home Care Agency service contractors with whom they have executed contracts. Full on-site monitoring occurs every two years. A new subcontractor must receive full monitoring for each of the first two years they are under contract. Abbreviated monitoring occurs each year when full on-site monitoring does not occur. Desk monitoring occurs semi-annually.

In addition to administrative review, consumer record and plan of care review, full on-site monitoring includes a fiscal review. The fiscal review consists of a comparison of a sample of contractor claims reports to contractor-maintained documentation of work performed. A review of individual employee time records is part of this responsibility. The minimum sample size is 5% of current authorizations. The monitoring activity verifies that work billed for was performed, that the contractor is maintaining documentation of work performed and that employees are paid for work performed.

An abbreviated review consists of a review of complaints and review of any items where compliance was not met during the full review. The abbreviated monitoring must be expanded to full when a subcontractor exhibits significant problems that are not corrected as required by corrective action.

Desk monitoring consists of a review of program and financial reports to compare level of service provided to the level of service authorized. Area Agencies on Aging's verification of a sample of time keeping records is required for home care agencies that exceed a ratio of provided versus authorized hours of 92% or above for the quarter reviewed. AAAs must require a written response from home care agencies that have a quarterly ratio of provided versus authorized hours that are equal to or less than 75%. If the reason for the underserved hours is primarily due to an agency's inability to appropriately respond to referrals or provide adequate staffing levels, a corrective action must be submitted by the agency.

Monitoring assures that providers are contracted appropriately and qualified to provide services. The Quality Management System requires that a statistically valid sample of provider files are monitored to ensure that verification of licensing, certification or any other required qualification is provided prior to execution of the contract. Payment cannot be made without a valid contract.

The State has a highly developed provider contract monitoring system as outlined in the approved Quality Management System. This includes monitoring a statistically valid sample of existing providers to ensure

that qualifications continue to be met. Washington re-verifies licensing or certification at the time of contract renewal and per individual licensing or certification schedule. If licensing and/or certification is not required, the State monitors based on qualifications in approved waivers and the State plan. We will use the existing system for providers under RCL.

If a provider is found not to meet qualifications, appropriate action is taken to rectify the situation. This may include termination of the contract if qualifications cannot be met.

Individuals in RCL (and in existing programs) can choose to self-direct their personal care. This means they hire, fire, train and supervise their own providers. Consumer Direct Care Network Washington (CDWA) is the contracted Consumer Directed Employer (CDE). To support adequate protections for consumers the CDWA oversees regulation, background checks, contracting and continuing education of individual providers. Specific and extensive requirements are noted in Washington Administrative Code (WAC 388-71). CDWA monitors individual provider files to ensure that these requirements are met. Providers who fail to meet requirements are not offered a contract or, for an existing provider, the contract is terminated.

The Quality Management System specifies response times for errors related to provider qualifications and conduct. Those requiring immediate response include payment errors; indications of abuse, neglect, and exploitation; consumer safety risks; consumer rights violations; poor quality of care with no indication that a referral, investigation, and/or action occurred. Policy also specifies the response time required to address the provider contracting/training problem that has been identified.

For Short Term Rental Assistance, OHAE follows the processes and procedures outlined below to prevent fraud and monitor activities:

OHAE uses Consolidated Housing Assistance Information (CHAI) as their internal database and repository of client data that documents client demographics, lease history, and client outcomes. CHAI interfaces with CARE for client assessment and services information.

Spokane Housing Authority (SHA) has contracted with HCLA to serve as the statewide administrator of HCS subsidies. By contract, SHA is required to verify the landlord/property owner, calculate rent/subsidy amounts based on local Fair Market Rent, complete annual recertifications/verifications, and recover overpayments of subsidies paid in error. SHA manages Housing Assistance Payment (HAP) contracts directly with landlords. OHAE is notified by SHA of any changes in tenancy (evictions, death, loss of contact, institutionalization, etc.). The short-term rental assistance housing plan can be referenced in Section F.2.

All HCBS Services are paid for through an FFS model in WA. Therefore, all HCBS claiming methodology is managed by HCLA.

B.4. Budget process

B.4.1. Budget development process

Describe how the state or territory will prepare the MFP budget. Include the following:

- Process for projecting annual expenditures
- Cross-agency roles and responsibilities for developing, reviewing, and approving the budget
- Procedures for adjusting or reconciling the budget

The budget process is a continuous cycle of actions throughout the year with strategic planning and collaboration by key personnel, identified below. Planning for the next year's budget starts with discussing the future of the program; including any expected changes to caseload or legislation that may impact the program. Once available, a full review and reconciliation of the prior year's spending is conducted and analyzed for effectiveness and accuracy. This includes a review of:

- Grant funded personnel roles and responsibilities
- Travel and supplies expenditures
- Subrecipient contracts
- Demonstration, Qualified, and Supplemental Services per capita costs

From here, the new budget is built. Updates and projections of annual costs such as personnel, benefits, travel, and subrecipient contracts are discussed with key personnel. Home and community-based service per caps are looked at individually for each of the Demonstration, Qualified, and Supplemental services. The most recent forecast data is then applied to projections to account for expected changes in costs of services per participant. The per caps are then applied to the anticipated caseload for the annual costs for the services.

Regular meetings are conducted with key personnel throughout the process to ensure the budget remains in line with the program priorities and goals.

Key Personnel:

- Budget and Fiscal Analysts
- MFP Project Director
- DDA Community Transition Unit Manager
- Tribal Initiative Project Manager
- HCLA Tribal Affairs Administrator
- Data and Quality Analyst
- Budget Forecast Chief

Once the budget is finalized, it gets approved across each division, then submitted to CMS for approval. The budget gets reconciled and reviewed quarterly to ensure spending is in line with projections. Throughout this process, any questions or concerns needing additional guidance are communicated and coordinated with our federal partners.

B.5. Other information

If needed, provide other information regarding the state or territory's MFP Demonstration administration that is not addressed elsewhere in the template.

Not applicable.

SECTION C. RECRUITMENT, ENROLLMENT, OUTREACH, AND EDUCATION

C.1. MFP-qualified inpatient facility recruitment

C.1.1. MFP-qualified inpatient facility types

In Table C.1.1, describe how the state or territory will collect and verify that MFP participants are transitioning to the community from an MFP-qualified inpatient facility. Describe the process for each target population and inpatient facility type. If there are multiple "other" populations to note, illustrate the type(s) of inpatient facilities separately for each "other" population with a new row.

Table C.1.1. MFP-qualified inpatient facility type by target group

Target population(s)	MFP-qualified inpatient facility types from which the target population will transition	Description of data collection and verification procedures
Older adults	☒ Nursing facility ☒ ICF/IID ☒ Hospital ☒ IMD	The process of verifying that Roads to Community Living (RCL) participants are transitioning from MFP-qualified inpatient facilities occurs at multiple phases. Case managers, who are assigned to these facilities, connect with potential RCL participants by providing program details. Interested participants complete a CARE assessment with their case manager, who then submits a referral to the RCL Enrollment Specialists. All institutional types are recorded in our CARE system, and RCL Enrollment Specialists manage enrollments for this target population. As part of the eligibility and enrollment process for RCL in IMD settings, specialists verify the participant's age. Additionally, several reports, as outlined in Section H, provide data on the institution types from which RCL participants transition, as well as their age and length of stay.
Individuals with PD	☒ Nursing facility ☒ ICF/IID ☒ Hospital ☒ IMD	The process of verifying that Roads to Community Living (RCL) participants are transitioning from MFP-qualified inpatient facilities occurs at multiple phases. Case managers, who are assigned to these facilities, connect with potential RCL participants by providing program details. Interested participants complete a CARE assessment with their case manager, who then submits a referral to the RCL Enrollment Specialists. All institutional types are recorded in our CARE system, and RCL Enrollment Specialists manage enrollments for this target population. As part of the eligibility and enrollment process for RCL in IMD settings, specialists verify the participant's age. Additionally, several reports, as outlined in Section H, provide data on the institution types from which RCL participants transition, as well as their age and length of stay.

Target population(s)	MFP-qualified inpatient facility types from which the target population will transition	Description of data collection and verification procedures
Individuals with I/DD	☒ Nursing facility ☒ ICF/IID ☒ Hospital ☒ IMD	As a result of the early success of the grant coupled with a corresponding change in philosophy at DDA, Washington takes a proactive stance for any individuals admitted to an RHC by developing discharge criteria immediately on a person moving to the facility. In addition, each newly admitted Medicaid eligible individual is given RCL information, making sure the program is fully explained. DDA staff track habilitative status and the readiness to move of these RHC residents in meetings twice monthly that involve RCL DDA Headquarters staff, DDA field services managers, DDA RCL Case Managers, and RHC intake/support staff. Each RHC has a designated RCL liaison (typically the intake/support staff person) to help coordinate RCL activities within their respective areas, working directly with the RCL planning team at the state level. In addition, at each yearly Individual Habilitation Plan meeting, DDA field and RHC staff provide information on the RCL grant opportunity and if the person and/or their family or legal guardian have interest, connects them with the RCL coordinator. Additionally, several reports, as outlined in Section H, provide data on the institution types from which RCL participants transition, as well as their age and length of stay.
Individuals with MH/SUD	☐ Nursing facility ☐ ICF/IID ☐ Hospital ☒ IMD	The process of verifying whether Roads to Community Living (RCL) participants are transitioning from MFP qualified inpatient facilities occurs at multiple phases. Residents are contacted briefly by their assigned case manager, and if they express interest in the project, they will receive further contact according to their needs and wishes and the Case Manager will complete the CARE assessment with the client. HCLA has specialized case managers assigned to different institution settings, such as hospitals and IMDs. All institutional types are loaded into our CARE system and as RCL Enrollments are managed by RCL Enrollment specialists for this target population, they confirm the institution is an approved institution type and will verify age as part of the eligibility and enrollment onto MFP for those in IMD settings to ensure individuals are not aged 21-64.
Other, please specify in text box below (e.g., HIV/AIDS, brain injury) Click or tap here to enter text.	☐ Nursing facility ☐ ICF/IID ☐ Hospital ☐ IMD	

Note: MFP programs transitioning MFP participants from an IMD (see PTC 14) must provide a description in section C.1.2 of the OP of how the state or territory will verify certain requirements, such as that the individual meets MFP individual eligibility criteria.
ICF/IID = Intermediate Care Facility for Individuals with Intellectual Disabilities; IMD = Institution for Mental Diseases.

C.1.2. Institution for mental diseases (IMD) exclusion

For MFP programs transitioning MFP participants from an IMD (see PTC 14), provide a description of how the state or territory will verify that the:

- Individual meets the MFP individual eligibility criteria

- Individual is receiving one of these benefits:
  - Services for individuals ages 65 and older in an IMD, referred to as “IMD over 65”
  - Inpatient psychiatric services for individuals younger than 21, referred to as “psych under 21”
  - Medicaid beneficiaries ages 21 through 64 residing in an IMD who are receiving services that are covered under a Substance Use Disorder or Serious Mental Illness section 1115 demonstration

All HCLA RCL Enrollments are managed by the RCL Enrollment Specialists at an HCS Headquarters level. The Enrollment Specialists verify the individual is receiving IMD over 65 or psych under 21 services, length of institutional stay, age and facility type. If needed, RCL Enrollment Specialists verify with the Department of Health and Health Care Authority to confirm the facility holds the appropriate licensure and qualifies as an IMD. This ensures that RCL enrollments meet all MFP eligibility criteria as outlined in the programmatic terms and conditions.

Similar to HCLA, DDA RCL Enrollments are managed by the DDA RCL Quality Improvement Specialist at the HQ level, confirming eligibility and compliance with all MFP Eligibility Criteria.

C.1.3. Strategies for recruiting MFP-qualified inpatient facilities

Describe strategies for recruiting MFP-qualified inpatient facilities to engage in the development and implementation of person-centered transition programs that offer residents the choice of leaving the facility to return to the community. Include geographic strategies, considerations specific to rural areas, alignment with state or territory Olmstead plans and rebalancing strategies, and facility access and engagement approaches.

Engaging MFP-qualified inpatient facilities in person-centered transition programs is a multi-faceted approach. HCLA assigns case managers to work directly with clients admitted to these facilities. By being embedded in the facility, case managers gain a deeper understanding of its operations, build rapport with staff, and foster collaboration. Because HCLA develops and implements person-centered transition plans, we help facilities recognize and support client choice while ensuring a safe and successful transition back to the community. These established relationships not only strengthen our ability to facilitate transitions but also create a foundation of trust that benefits both clients and facility staff. This approach is especially valuable in rural areas, where facilities may be more limited but still have assigned case managers who are familiar with services within that area as well as their unique challenges. Their local expertise helps ensure that rural facilities receive the same level of engagement and support as those in more populated areas, allowing for effective transition planning across all communities.

In addition to in-person collaboration with facilities, targeted marketing materials serve as another key strategy for engagement. Websites and concise, easy-to-read informational flyers with contact details are distributed in various settings, including institutional facilities and high-traffic community locations such as medical clinics and community centers. These materials provide essential information about the demonstration project, available support, financial resources, funding and benefit programs, housing options, independent living supports, health services, supplies and equipment, transportation options, social and recreational resources, and employment support services.

To ensure broad dissemination, we utilize existing mailings and communication channels to reach MFP-qualified institutional settings. Key materials are also available on internal and external HCLA websites, and we leverage established relationships with stakeholder groups to distribute educational information to consumers. Additionally, HCS conducts annual training at Nursing Facility Association conventions, focusing on how the program supports residents in transitioning to HCBS through the MFP demonstration. Within rural geographical areas throughout the state, HCS provides opportunities and

takes into consideration the need for continued outreach and recruitment for MFP participants. These outreach efforts are also outlined in the WA State Olmstead Plan.

C.2. MFP participant recruitment and enrollment

C.2.1. Eligibility criteria for participation in MFP

Describe any state or territory-specific MFP eligibility criteria. For example, describe your state or territory's requirements for individuals' length of stay in an MFP-qualified inpatient facility if more than 60 consecutive days. See section IV of the MFP PTC for a description of MFP eligibility criteria.

The state follows eligibility criteria as outlined in the programmatic terms and conditions. Washington uses no additional criteria for MFP.

C.2.2. Participant recruitment and enrollment process

Describe the MFP participant recruitment and enrollment process, indicating differences as applicable for each target group and inpatient facility type identified in C.1.1. Include the following:

- Describe the process to identify eligible individuals interested in transitioning from an inpatient facility to a qualified residence.
- Describe the role of No Wrong Door (NWD) systems to recruit and enroll MFP participants.
- Describe how the state or territory will verify MFP individual eligibility criteria.
- Describe the provider(s) rendering services to recruit and enroll individuals into MFP.
- Describe how the state or territory will ensure a person-centered planning process during the MFP recruitment and enrollment process. The person-centered planning process must include a person-centered service plan that identifies the individual's needs and individualized strategies and interventions for meeting those needs, and be led by the individual and the individual's legally authorized representative if applicable.

Washington does not have contracted provider(s) rendering services to recruit and enroll individuals onto MFP.

Home and Community Services (HCS)

The process to identify eligible individuals interested in Roads to Community Living is face-to-face interviews, data analysis, consultation with staff, and technical assistance as needed. Education and outreach, and the ability to accept self-referrals play an important role in our strategy.

HCS assigns case managers to each MFP-qualified institution. Within nursing facilities, Washington takes a proactive stance, seeing each newly admitted Medicaid eligible individual within the first ten days of admission or Medicaid conversion. Each case manager is responsible for working with residents in 2-3 centers. There is no recommended case load per case manager. Work is distributed utilizing the following considerations:

- Turnover rate of Medicaid residents in each facility,
- Medicaid census in each nursing facility
- Medicare census in each facility,
- Geography: distance between centers

The census and history of turnover at each site determines the number of visits per site and the number of staff assigned to each site. For most nursing facilities HCS case managers will be on site a minimum of once a week. In addition to on-site visits, Home and Community Services uses Minimum Data Set

(MDS) information collected through the Resident Assessment Instrument for nursing home residents to identify individuals who may be ready and interested in transition. These individuals will be contacted briefly by the Nursing Facility Case Manager assigned to that facility to determine if they are interested in relocating and the RCL program.

Case managers assigned to Institutions for Mental Disease (IMD), like those in nursing facilities, must initiate contact within three working days of receiving the new intake assignment. If the individual expresses interest in service, the case manager must begin the comprehensive assessment and resident evaluation within seven days. Similarly, case managers assigned to acute care hospitals must contact the individual within two working days of receiving a referral.

In all institutional settings, case managers, who may be social workers or registered nurses, contact residents to inform them of their right to decide where they will live. A comprehensive assessment and resident evaluation (CARE) is completed when the individual indicates an interest in relocation, and a person-centered transition plan is developed jointly. Once information is entered into the CARE tool, various reports can be generated for each facility type that provide information regarding age and length of stay. These assist regional and headquarters staff in identifying potential RCL enrollments at-a-glance.

Washington State has a No Wrong Door system when it comes to recruitment and enrollment of RCL participants. Institutional settings can make referrals by contacting Home and Community Services. Individuals can make self-referrals and contact the RCL team directly. The state's HCS RCL website and outreach materials provide contact information for individuals and family members to utilize.

At time of referral HCS RCL Specialists verify the following:

1. 60-day institutional stay as qualified setting documented by the case managers in the state's CARE tool.
2. Medicaid eligibility in the State's Automated Client Eligibility System (ACES).
3. Functional eligibility as determined in the Comprehensive Assessment Reporting & Evaluation (CARE) system.

Developmental Disabilities Administration

For state operated Residential Habilitation Centers, Washington also takes a proactive stance, providing targeted criteria for stabilization and discharge within the first month after admission. During that process, information related to the MFP-RCL grant is provided for the newly admitted Medicaid eligible individual. The facility intake worker is also the facility discharge worker, so the stabilization goals, and progress toward those goals are consistently tracked. The intake/discharge worker is also in bimonthly contact with Regional Transition staff, to make sure up-to-date information regarding rehabilitative status for each individual is available.

Once a person is stable and reaches transition status, the facility intake/discharge worker contacts field services transition case managers who contact the resident to remind the person of their right to decide where they will live. Along with the facility interdisciplinary team, the person and the team will discuss the person's preferences, identify barriers to community transition and likely support needs, as well as reviewing the supports that are available in the community and other possible service options. A comprehensive assessment reporting & evaluation (CARE) assessment is completed when the individual indicates an interest in relocation, and a transition plan is developed jointly. The individual's desire to relocate and available community options are reviewed again at this time.

As with HCLA, for DDA individuals have ability to make self-referrals and can contact the MFP team directly for enrollment. The state's RCL DDA website and outreach materials have contact information for individuals and family members to utilize.

When the individual decides to enroll in RCL, the DDA Quality Improvement Specialist verifies the 60-day institutional stay in a qualified setting, documented by the case managers in the state's CARE tool, Medicaid eligibility, and functional eligibility.

HCS/DDA case managers meet and identify clients who are interested in transition planning, the case manager will complete a Comprehensive Assessment Reporting & Evaluation (CARE) assessment with the client. This standardized assessment process always includes a face-to-face interview with the client, family, legal decision maker (if applicable), and others of the client's choosing. Through this process, they collaboratively gather and document essential information, including needs, goals, strengths, limitations, resources, preferences, and level of care requirements. Based upon policy outlined in HCLA's Long-Term Care (LTC) Manual, Chapter 3, the assessment process leads to the development of a person-centered plan of care encompassing services needed by the client while determining availability of informal supports and other non-department paid resources and community resources. Informal supports are any unpaid resources available to fully or partially complete individual Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL) tasks identified in the client's care plan. Identified informal supports are based on voluntary action and are available so long as the source is willing and able to continue them. The person-centered plan includes the client's choice of living situation, what services the individual is eligible for, limits on authorized hours, and any additional supports needed as identified in the assessment. The individual and/or their legal decision maker must agree to their person-centered plan in writing to be considered finalized.

C.2.3. Data sources for recruiting MFP participants

Describe how the state or territory will process and organize data sources to identify and recruit MFP participants. The description must include the use of the Minimum Data Set (MDS) Section Q and must describe any variability among MFP target populations, MFP-qualified inpatient facilities, and state or territory operating agencies.

Home and Community Services utilizes multiple data sources and reporting tools to identify and recruit participants for the MFP program. Standardized reports are available that extract data from the CARE tool, which tracks information across all MFP-qualified institutional settings and target populations. These reports include key data points such as admission dates to assess length of stay and dates of birth to determine eligibility based on age (for IMDs). Additionally, ad hoc reports can be generated based on specific business needs, pulling data from both the CARE tool and MMIS claims. To ensure efficient identification and recruitment, the MFP team systematically integrates and analyzes these data sources to pinpoint potential participants. For more details on specific reports used for MFP program management, see Section H.

The Minimum Data Set (MDS) information collected through the Resident Assessment Instrument for nursing home residents is utilized to identify potential participants for case managers to connect with. The MDS information is reviewed at least monthly by the RCL Enrollment Specialists and area specific information is shared with regional supervisors and case managers. Regional staff utilize this data to identify nursing facility residents who may be ready for transition and eligible for RCL.

C.3. Outreach and marketing to participants, providers, and the community

C.3.1. Marketing plan

Describe how the state or territory will develop and implement a marketing plan to recruit and enroll MFP participants. Include a description of the following:

- Strategy or strategies to provide cultural, linguistic, and disability competency in the production and dissemination of marketing materials
- Types of marketing materials and tools
- Types of media approaches (print, radio, television, direct mail, social media, search engine, and so on)

Upload printed marketing materials or provide an external link to the materials in the appendix, as appropriate.

Marketing materials created for outreach and marketing to participants, providers, and stakeholders are developed in collaboration with the HCLA Communications Team and vetted by the DSHS Headquarters Visual Communications Unit. For language access, MFP materials and visual media can be provided in nearly any language or dialect needed. For accessibility access, an established contract with Quality Logic provides PDF remediation on all digital PDF documents that are shared on the website or via email with the public. Standard accessibility work provided by the Communications Unit includes alt text for images in PDFs and social media graphics, captions on all videos, Web Content Accessibility Guidelines (Version 2.1, Level AA) color contract ensured on all design and video graphics, accessible font selection used in all design and video graphics, culturally sensitive and disability diverse images curated across all media – which can be discussed and reviewed throughout the media creation process. This includes using images of Native families and peoples developed by HCLA by an Indigenous creative agency for Indigenous community materials.

The MFP team employs a comprehensive marketing strategy to recruit and enroll participants, utilizing a mix of print, digital, and direct engagement tools. Our approach includes traditional media such as a brochure and newsletters, as well as digital outreach through our website and newsletter. To enhance visibility at events and conferences, we use branded materials like presentation posters and tablecloths. Additionally, we distribute reusable bags, small notebooks and pens, pop sockets, and stickers to facilities where potential MFP participants are admitted. These materials reach both potential enrollees and the staff working directly with them. A video highlighting an overview of the RCL program and a success story serves as a key marketing tool, providing an engaging way for potential enrollees to learn about the program beyond traditional written materials.

C.3.2. Outreach and education plan

Describe how the state or territory will develop and implement an outreach and education plan to recruit MFP-inpatient facility providers, service providers, affordable and accessible housing providers, community-based organizations, and other relevant entities. Include a description of the following:

- Methods and tools
- Collaboration opportunities
- Types of events and trainings

Upload outreach and education materials into the appendix or provide an external link.

Washington State will utilize targeted outreach methods, training events and collaborative opportunities to ensure widespread awareness and engagement.

Methods and Tools:

- Monthly Nursing Facility Case Management (NFCM) Collaboration Meetings: HCLA MFP HQ staff facilitate regular meetings with regional NFCM leadership to discuss updates, address challenges, and provide outreach and education.
- Transition Improvement Committee (TIC) Meetings work as a committee with front line case management staff at HCS to highlight MFP, and work to develop and adjust additional services and supports for MFP.
- Case Management Engagement: HCLA MFP HQ staff routinely meet with case management units, individual case managers, regional local state offices and AAA offices to provide training and refresher sessions on MFP services and supports. Websites are available to case managers, contracted providers, HCLA MFP HQ posts program updates, training opportunities through recorded videos, available in person meetings, and available resources and supports to enhance and recruit MFP participants.
- Nursing Facility Outreach & Training: HCLA MFP HQ staff conduct direct outreach to nursing facility operators, hospitals, and direct facility care staff offering training on MFP services and supports utilization to encourage recruitment. These training events also occur annually at Nursing Facility Association Conferences, LTC Ombuds annual meeting and at the Public Guardianship conferences.
- MFP HQ staff regularly participates in complex client staffing with institutional settings. These discussions include multidisciplinary members working together for effective community-based discharge planning. MFP HQ staff can highlight possible services and supports provided by MFP and identify eligible clients for the program.
- DDA Transition Focused Meetings: Weekly check-ins with the RHC Interdisciplinary Treatment Teams, the statewide PASRR team, and the statewide transition teams are the main tools used for getting information to recruiting and tracking transition-ready individuals.
- Mentorship: DDA uses family mentors, who are parents of individuals who have transitioned from institutional settings to the community, to support families through the decision process related to the transition of their relative to the community. Peer mentors, who are individuals with developmental disabilities who have moved to the community, work with clients who are interested in transition to support them in the process. These mentors distribute information related to MFP-RCL.
- Resource Development & Distribution: Education materials, program guidelines and marketing materials will be made available to stakeholders through digital and printed materials. These include:
    - HCS RCL Website
    - DDA RCL Website
    - Tribal Affairs MFP Website
    - RCL Brochure
    - RCL Newsletter Subscription Sign Up

- RCL Video
- RCL Fact Sheet
- DDA RCL Fact Sheet
- HCLA LTC Care Manual Chapter 29: Roads to Community Living
- Nursing Home Guidelines (The Purple Book)
- Nursing Facility Transitions with HCBS
- Supported Living Program Locator - WA State
- RCL logo branded merchandise: stickers, notebooks and reusable bags
- Technology Support Services Flyer (below)

Collaboration Opportunities:

In addition to collaborating with case managers, local AAA offices, tribal partners, LTC Ombuds, nursing facility operators and Hospitals to expand outreach, enhance service coordination and improve access to MFP, MFP staff also collaborate with:

- Managed Care Organizations-Amerigroup Wellpoint of WA, Community Health Plan of Washington, Coordinated Care of WA, Molina, and United Health Care. All 5 of the MCOs that are contracted with WA state provide weekly updates on SNF admissions and who the MCO contact is to assist DSHS Case Managers with medical services coordination.
- HCLA Housing Unit-Monthly meetings between the RCL Policy Unit and the Housing and Employment unit to discuss coordination and sharing of housing resources. Additional affordable housing outreach information can be found in Section F.2.
- HCLA Resource Support & Development unit, which identify and support providers through the contracting process, helping to expand the provider network and increase service options to MFP participants.
- Tribal Community collaborations: Coordinate and collaborate with MFP Tribal community partners providing education on MFP services and supports, recruitment and outreach along with Tribal owned Colville Convalescent Center staff. Connecting with Tribal AAA case managers directly to provide resources and supports. MFP Tribal Initiative focuses on developing inclusive service contracts and engaging potential partners at the state, tribal and county levels for improved and culturally inclusive service delivery of HCLA Services. Government to Government collaboration and partnership.
- Quarterly meetings and trainings with Community Choice Guides which are a contracted service which supports complex and time intensive transition planning in coordination with HCLA Case Management staff and clients relocating from institutional settings to HCBS.
- DDA staff regularly meet with the state Developmental Disabilities Council staff, The Arc of Washington staff, the DD County Coordinators, Developmental Disabilities Ombuds, and the

Community Residential Services Association to give updates related to MFP and provide opportunities for continued collaboration.

- Internal meetings with the DDA Residential Unit, DDA Employment Unit and DDA Housing Unit give the MFP-RCL team an opportunity to collaborate with and support these teams' efforts to increase community resources.

Types of Events and Trainings:

MFP staff provide additional training at key events to educate and engage stakeholders. Where providers, community organizations and agencies can learn about MFP services and resources. These include

- Tribal Summit- In person Government to Government conference to collaborate with various Tribes, Leaders, Elders together to share ideas, and work towards improving and supporting lives of elder's and family members through HCLA services and supports.
- Washington Health Care Association (WHCA) Conferences- Annual conference that provides educational sessions designed to meet the needs and challenges at every level of long-term care, including specialized topics for caregiving staff, administrators, and owners of for profit nursing facilities and assisted living facilities.
- Leading Age Conference- Annual outreach to CEO's, directors, coordinators, nurses, care staff, and strategic partners to gain knowledge and share information and build relationships that are current with our aging population for mission driven or non-profit nursing facilities and assisted living facilities.
- LTC Ombudsman Program-Annual outreach and presentation at their in-person program meeting.
- Resource Fairs-These are held at minimum yearly at each of the 4 RHCs. These events include community residential and employment services providers, person centered planning practitioners and DDA staff to provide written MFP-RCL information and answer questions about the program.
- Community Summit-Statewide annual event used to connect the community (DDA clients, families and professionals) with cutting edge technology and resources such as MFP-RCL.
- The Person-Centered Planning Symposium is an annual event geared towards expanding person-centered planning across Washington State. The two-part symposium begins with regional action sessions where self-advocates and others identify opportunities and create goals to expand and strengthen person-centered planning access throughout the state. Part two is the culmination of the larger symposium where the participants of the regional action sessions come together to share their goals, progress, and ideas to shape the future of person-centered planning across Washington.
- Statewide Nursing Facility Case Management Conference-hosted by HCLA to provide statewide in person network and education to case managers regarding person centered care planning, transition resources and best practices.
- Office of Public Guardianship- Annual training on the Roads to Community Living program, services and supports available to those clients with guardianship support for decision making.

This coordinated approach for outreach and education will help ensure a well-informed network of providers and partners.

C.3.3. Stevens Amendment and accessibility requirements

Select the boxes below to confirm the state or territory adheres to the requirements regarding the Stevens Amendment and complies with accessibility laws.

☒ The state or territory affirms that it has established procedures for complying with the requirement in Section 26.G and 26.H of the CMS Standard Terms and Conditions (STC) regarding the Stevens Amendment, which describes actions federal award recipients must take when engaging in public reporting and acknowledgement of sponsors.

☒ The state or territory acknowledges responsibility for complying with federal laws regarding accessibility (Attachment B of CMS STC).

C.4. Informed consent

C.4.1. Informed consent criteria

Describe how the state or territory will implement procedures for obtaining informed consent. Include the following:

- Process for ensuring that each eligible individual or the individual's legally authorized representative will be provided the opportunity to make an informed choice regarding whether to participate in the MFP Demonstration
- Process for ensuring that each eligible individual or the individual's legally authorized representative will have input into, and approve the selection of, the qualified residence in which the individual will reside and the setting in which the individual will receive HCBS
- Process for ensuring individuals are informed about all aspects of the transition process; have full knowledge of the services and supports that will be provided both during and after the program year; and are informed of their rights and responsibilities as a participant, including the right to file reports or complaints regarding violation of their rights or other critical incidents
- Method(s) for obtaining informed consent (written, verbal, digital, and so on)

Provide an external link to informed consent forms and informational material. Alternatively, paste or embed those materials into the appendix or the text box below. If using the appendix, use the text box to indicate where in the appendix these materials can be found.

Washington has several mechanisms for assuring those individuals, their legal representatives and families are informed of choices and rights regarding home and community-based services. The current practices summarized below will continue with RCL:

- Individuals participate in a standardized assessment process that always includes an in-person interview with the participant, family, legal representative and others of the individual's choosing. Together the assessor, the participant and any others listed above, document needs, goals, strengths, limitations, resources, preferences, and level of care requirements using a uniform, comprehensive system.
- By policy, the assessment process leads to the development of a person-centered plan of care encompassing services needed by the individual without minimizing or undermining existing supports provided by the family and other significant individuals in the participant's life or community. Family or legal representatives and other natural supports are always included to the extent possible as agreed to by the person.

- The plan of care includes both formal and informal providers of support and personal goals identified by the individual.

Case managers review the “Client’s Rights and Responsibilities (DSHS 16-172)” document with consumers and obtains the client’s signature on this form. This document outlines the individual’s right to participate in the development of their plan of care and ensures that their preferences and the available services they wish to receive are included. Client’s Rights specify that, as a consumer of DSHS services, individuals have a right to:

- Be treated with dignity, respect and without discrimination;
- Not be abused, neglected, financially exploited, or abandoned;
- Have your property treated with respect;
- Not answer questions, turn down services, and not accept case management services you do not want to receive. However, it may not be possible to offer some services if you do not give enough information;
- Be told about all services you can receive and make choices about services you want or don't want;
- Have information about you kept private within the limits of the laws and DSHS regulations;
- Be told in writing of agency decisions and receive a copy of your care plan;
- Not be forced to answer questions or do something you don't want to;
- Talk with your social service worker's supervisor if you and your social service worker do not agree;
- Request a fair hearing;
- Have interpreter services provided to you free of charge if you cannot speak or understand English well;
- Take part in and have your wishes included in planning your care;
- Choose, fire, or change a qualified provider you want; and
- Receive the results of the background check for any individual provider you choose.

The assessment process leads to the development of a person-centered plan of care encompassing services needed by the client while determining availability of informal supports and other non-department paid resources and community resources. The individual or their legal representative signs and receives a copy of the plan of care.

Informed consent is always obtained directly from the person unless he/she/they are legally not competent to consent. In that event, State statute (RCW 7.70.065) allows the following in order of priority to give informed consent for adults: legal guardian, Durable Power of Attorney, spouse or State registered domestic partner, adult children, parents and adult siblings. For children, custodial parents provide informed consent unless there is a court appointed guardian. An “Acknowledgement of Services” form (DSHS Form 14-225) is used to document the person’s freedom to choose between institutional and home and community-based services. The choice is explained to the person and their legal representative if appropriate, and a signature is obtained stating that the individual understands they have a choice in the type of services received, where the services are provided as well as the right to a fair hearing. All MFP, 1915 (c) and 1915 (k) recipients sign this form. In addition to all the above, Washington

has developed an enrollment form, embedded below, which is provided to individuals who wish to participate in the demonstration.

For consumers of the Developmental Disabilities Administration, a further step is being taken. Case resource managers are required to make sure that each person has the necessary supplemental accommodation (NSA) to ensure that the person understands any action DDA is taking concerning them. If a person does not have an NSA, and needs a guardian, then guardianship will be pursued. Clients who have a mental, neurological, physical, or sensory impairment or other problems that prevent them from getting program benefits in the same way as those who are not impaired, are considered in need of NSA.

An NSA is involved to ensure that a participant who may have difficulty accessing program benefits for any reason (disability, language) will get help in doing so. In HCLA, we ask whether consumers need this service. In DDA, it is provided to all applicants.

RCL Enrollment Form 12.2024 - BLAN

C.5. Legally authorized representative

C.5.1. Procedures for MFP engagement with a legally authorized representative

Describe how the MFP Demonstration will engage with a legally authorized representative and how the process aligns with state or territory policy. Include the following:

- Procedures for engaging with a legally authorized representative as part of an individual's person-centered planning process during the transition period and the 365-day MFP enrollment period
- Specific strategies and approaches when working with inpatient facility administrators who are serving as a legally authorized representative, particularly around identifying and eliminating conflict of interest concerns
- Process for verifying that an MFP participant's legally authorized representative has (1) a known relationship with the individual; (2) ongoing interaction with the individual; and (3) recent knowledge of the individual's welfare

Facility administrators are not permitted to serve as authorized representatives for residents of their facilities.

The HCS/DDA case manager must have documentation of approval from the client or duly appointed representative (durable power of attorney or guardian) for the person-centered plan of care. Clients are considered legally competent unless deemed incompetent by a court of law. A reasonable effort must be made to have the client's approval and signature on documents if there is no court order deeming them incompetent. Even if client has an active durable power of attorney (DPOA) or guardian, the case manager looks to the client directly to make choices about Medicaid services, to the extent possible. A client may also choose a representative who is not a DPOA or guardian, to act on their behalf to make decisions about Medicaid services and supports. If the client can indicate their free choice to authorize a representative, the representative may be allowed to make decisions about the client's Medicaid services.

Guardians are always asked to participate in care planning that occurs yearly and at other times as needs change. For individuals who have court appointed guardians, no transitions will be made under RCL without the consent of the guardian. Guardians are required by statute (RCW 11.130) to file an annual report which includes:

1. The address and name of the incapacitated person and all residential changes during the period;

2. The services or programs which the incapacitated person receives;
3. The medical status of the incapacitated person;
4. The mental status of the incapacitated person;
5. Changes in the functional abilities of the incapacitated person;
6. Activities of the guardian for the period;
7. Any recommended changes in the scope of the authority of the guardian or legal representative; and
8. The identity of any professionals who have assisted the incapacitated person during the period.

Similar to other HCBS programs, RCL will involve guardians throughout the person-centered care planning process. Guardians will be informed about the demonstration program at the time the person-centered care plan is being developed. As the legally appointed representative of the consumer, guardians are an integral, mandatory part of the institutional interdisciplinary teams for everyone residing at DDA RHCs, nursing homes, and hospitals.

Corporate guardians or guardians who might not be interested in a high level of involvement will, at a minimum, be responsible for providing informed consent per statute. If a guardian is not attending to the health, safety and welfare of the individual, there is a legal process to have another guardian appointed.

C.5.2. Re-enrollment

Describe the state or territory's MFP re-enrollment policy (1) for individuals who have been re-institutionalized or hospitalized prior to completing their 365-day MFP enrollment period, and (2) for individuals who have been re-institutionalized after completing their 365-day MFP enrollment period. Include actions that occur at 30- and 60-day intervals during an individual's institutional or hospital stay.

HCS/DDA HQ MFP staff will be notified when a client has been reinstitutionalized during the demonstration period. RCL Enrollment specialists will document disenrollment from MFP when the individual has been re-institutionalized for a minimum of 30 days. The RCL Enrollment Specialist will support re-enrollment and transition activities to include monitoring the individual's length of stay. This action of disenrollment due to reinstitutionalization, and reenrollment and subsequent discharge recalculates the RCL Demonstration period enabling participants to use the remaining 365 days in the community. Case Managers collaborate with clients to reduce transition barriers and address the conditions which resulted in re-admission. The Case manager and the client work together to create an updated person-centered care plan and coordinate with institution staff on effective discharge planning. Additionally, RCL Enrollment specialists have created and review a report for MFP reinstitutionalized participants to proactively support reintegration into the community.

For those participants who have completed a full MFP demonstration year, these individuals will be eligible for RCL services if they experience a subsequent 60 day or greater institutional residency. A new Comprehensive Assessment Reporting and Evaluation will be conducted, and a new person-centered plan of care is developed. This assessment will identify and address existing conditions that led to re-institutionalization.

C.6. Other information

If needed, provide other information regarding the state or territory's approach to recruitment, enrollment, outreach, and education that is not addressed elsewhere in the template.

Not applicable.

SECTION D. COMMUNITY ENGAGEMENT

Describe how the state or territory will engage the broad community, including but not limited to, Medicaid agency leadership, participants in HCBS programs, residents in long-term care facilities, long-term care facility staff, family members and other caregivers, HCBS providers, the aging and disability network, MCPs, housing providers, and the direct care workforce, to inform the state or territory's approach to the design of the MFP Demonstration and how the state or territory can leverage the MFP Demonstration to expand and enhance the HCBS system. Include a description of the state or territory's strategy(s), structure of the engagement process, engagement tools, communication process, and how the process will be strengthened throughout the MFP program period of performance.

Washington State's approach to community engagement for the Money Follows the Person (MFP) Demonstration, also known as the "Roads to Community Living" project, involves a comprehensive and inclusive strategy. The state emphasizes collaboration with a wide range of internal and external partners to design and enhance its Home and Community-Based Services (HCBS) system.

Strategies for Community Engagement

Inclusive Engagement: Washington State actively involves Medicaid agency leadership, HCBS participants, long-term care residents, facility staff, caregivers, providers, and other key groups. This ensures diverse perspectives are considered in the program's design and implementation.

Culturally Inclusive Services: The state prioritizes culturally inclusive service systems, particularly for American Indian/Alaska Native communities, by developing partnerships with tribal organizations.

Annual Summits and Listening Sessions: Regular events, such as summits and listening sessions, provide platforms for stakeholders to share insights, successes, and best practices.

Engagement Tools and Communication

One-on-One Support: Participants receive personalized assistance to transition from institutional settings to community living.

Person-Centered Planning: The program emphasizes individualized plans that address specific needs and preferences.

Feedback Mechanisms: Tools like surveys and focus groups are used to gather input from stakeholders.

Strengthening the Process

MFP in Washington State has deep roots in strengthening relationships with community partners to maximize successful community living. Throughout the program's performance period, DSHS aims to expand partnerships with community organizations and housing providers, enhance communication channels to ensure transparency and accessibility, and continuously evaluate and adapt strategies based on stakeholder feedback.

This collaborative and adaptive approach ensures that the MFP Demonstration not only meets its goals but also strengthens the HCBS system for the long term.

DDA continues to use the Washington State Developmental Disabilities Council (DDC) to update stakeholders on MFP-RCL unit activities and uses the DDC to help publicize the RCL program. Presently, the DDC is comprised of 7 DDA clients, 12 family members of DDA clients, and representatives from State agencies including DDA, DVR, mental health, commerce, Department of Health, public instruction, the University of Washington, and the advocacy group Disability Rights Washington (DRW). In addition, DDA RCL continues to participate in a Communities of Practice resource group, where MFP as well as other community-based resources are discussed. The group is comprised of 3 self-advocates and 5

family members, as well as representatives from 3 advocacy groups, 4 state agencies, 2 county agencies and the University of Washington. Both meet quarterly.

D.1. Community engagement process

States or territories may use Example Table D.1 to list those engaged in the design and implementation of the MFP Demonstration; to indicate the related OP element(s); and a brief description of the engagement structure, including the type and frequency of engagement and role(s) in the engagement process.

Example Table D.1. Description and frequency of community engagement

Entities (examples)	OP elements	Description of the engagement process
MFP participants	Recruitment, Enrollment, Outreach, and Education/ Benefits and Services/ Transition and Housing Services/ Self-Direction and Informal Caregiving/ Quality Measurement, Assurance, and Monitoring/ Continuity of Care Post Demonstration	The care plans offered through RCL will encompass home and community-based services tailored to the circumstances and needs of individual participants. RCL care plans will be coordinated with allied systems including primary care, mental health, substance abuse, vocational rehabilitation and housing. Outcome and satisfaction measures are collected by experience of care surveys and through the Service Experience Team at both the local and state level in a systematic way to provide analysis at all levels of the organization and to inform them where changes should take place. Staff are well-trained on waiver eligibility, customer service, technical skills, quality assurance, and policies and procedures. Problems and concerns are identified and are used to determine strategies that will ensure continuous improvement.
Residents in inpatient facilities	Recruitment, Enrollment, Outreach, and Education/ Benefits and Services/ Transition and Housing Services/ Self-Direction and Informal Caregiving/ Quality Measurement, Assurance, and Monitoring/ Continuity of Care Post Demonstration	Bi-weekly meetings with DDA Transition Staff and Residential Habilitation Center Staff.
Family members and caregivers	Recruitment, Enrollment, Outreach, and Education/	Case managers will provide outreach and connect with family members or other individuals who are important to the client at the direction of the client and as outlined on the Release of Information. Written materials, electronic

Entities (examples)	OP elements	Description of the engagement process
	Benefits and Services/ Transition and Housing Services/ Self-Direction and Informal Caregiving/ Quality Measurement, Assurance, and Monitoring/ Continuity of Care Post Demonstration	newsletters and the MFP websites also provide information to family members and caregivers.
Centers for Independent Living	Transition and Housing Services/ Benefits and Services	Have contracted and hired several centers for independent living to work as contracted providers across the state to work directly with our clients moving to community-based settings from institutions.
Long-term care facilities	Transition and Housing Services/ Recruitment, Enrollment, Outreach, and Education	Case Managers connect at least weekly with facilities that they are assigned across the state. HQ also provides direct support for facilities to educate regarding MFP and work collaboratively on discharge planning.
HCBS providers	Benefits and Services/ Transition and Housing Services/ Continuity of Care Post Demonstration	Contracted providers who support transition and community sustainability are encouraged to participate in regularly scheduled quarterly meetings. Additional training and skill-building opportunities are also offered on a quarterly basis, as well as a web-based training platform where resources and tutorials are available on demand.
Housing partners	Transition and Housing Services/ Continuity of Care Post Demonstration	Staff work with local public housing authorities and providers to identify appropriate units of housing for eligible individuals as they are preparing for discharge. This includes identifying options for accessibility and affordability on an individual basis. For example, when an eligible individual is planning to transition to a specific community and utilizes an electric wheelchair, staff will work with the housing provider to ensure that the available unit is completely accessible to that specific person's needs, including subsidized rental voucher assistance when needed.
Managed care plans	Benefits and Services/ Continuity of Care Post Demonstration	Beginning in July of 2024, the Health Care Authority or Managed Care Organizations began providing Community Behavioral Health Support (CBHS) services to Medicaid recipients in licensed residential settings. These interventions are not related to the provision of personal care but include behavioral health services by a behavioral health agency. Home and Community Services coordinates with the MCOs during regularly schedule transition coordination meetings on a statewide level for

Entities (examples)	OP elements	Description of the engagement process
		CBHS and coordination of medical benefits in the community.
Aging and disability networks	Continuity of Care Post Demonstration/ Self-Direction and Informal Caregiving	Regularly scheduled meetings with the State Council on Aging, Washington Association of Area Agencies on Aging, Senior Centers, State Units on Aging
Direct care workforce	Benefits and Services/ Self-Direction and Information Caregiving/ Continuity of Care Post-Demonstration	Regularly scheduled meetings with Contracted Providers and Washington State Health Care Association and LeadingAge Washington are both Nursing Facility and Assisted Living Associations. Washington State Adult Family Home Council.
HCS and DDA Regional Administrators	Project Administration/ Recruitment, Enrollment, Outreach and Education	Meetings at least quarterly to discuss programmatic progress and challenges.
Other	Recruitment, Enrollment, Outreach, and Education	Meetings with Regional LTC Ombudsman Indian Policy Advisory Committee The State maintains a government-to-government relationship with the federally recognized Tribes in the state. This includes written accords, a formal process for consultation and process for informal input. Office of Public Guardianship-trainings to public guardians regarding the Roads to Community Living program.

D.2. Other information

If needed, provide other information regarding the state or territory's approach to engagement that is not addressed elsewhere in the template.

Please see Section M: Tribal Initiative.

Please see Section C: Recruitment, Enrollment, Outreach and Education.

SECTION E. BENEFITS AND SERVICES

Describe how the MFP Demonstration will provide opportunities for MFP participants to receive high-quality services in their own homes or community rather than institutions. The state or territory must describe qualified HCBS (PTC 16 and Attachment A in the PTC), Demonstration services (PTC 17), and supplemental services (PTC 24) that it will provide under the MFP Demonstration.

E.1. Qualified HCBS

The qualified HCBS program is the Medicaid service package(s) that the state or territory will make available to an MFP participant when they move to a community-based residence. This program can be comprised of any Medicaid home and community-based state plan services and HCBS waiver program services. MFP-qualified HCBS are listed and described in Attachment A to the MFP PTC.

The state or territory must describe:

- Qualified HCBS available to MFP participants
- Target population
- Any proposed Medicaid coverage strategy to amend and implement changes to the state plan or HCBS waiver program(s) to carry out the Demonstration; these descriptions must indicate:
  - The specific HCBS program that will be changed or amended
  - Which authority the HCBS program operates under
  - When the change or amendment will occur

The state or territory may insert information using (1) Example Table E.1, (2) a description in the text response box below, or (3) a combination of both a table and a separate text description.

Example Table E.1. MFP-qualified HCBS

MFP-qualified HCBS	Qualified HCBS description	MFP target population(s)
HCBS under section 1905(a) state plan services	Personal Care	**Older Adults, Adults with Disabilities, I/DD, Individuals with MH/SUD**

HCBS under sections 1915(c), 1915(i), 1915(j) and 1915(k)	**<u>Home and Community Services</u>** Personal Care Durable Medical Equipment/Specialized Equipment and Supplies Community Choice Guiding Non-Medical Transportation Client Training-Medical and Non-Medical Behavior Support Consultation and Stabilization Services Assistive Technology Technology Support Consultation and Technical Assistance Community Transition Goods and Services Skilled Nursing Nurse Delegation Home Health Aide Adult Day Care Caregiver/recipient Training Home Delivered Meals In-home nurse delegation Specialized Medical Equipment and Supplies Personal Emergency Response Systems Adult Day Health Wellness Education Private Duty Nursing **<u>Development Disabilities Administration</u>** Personal Care Durable Medical Equipment/Specialized Equipment and Supplies Non-Medical Transportation Client Training-Medical and Non-Medical Life Skills and Stabilization Services Assistive Technology Technology Support Consultation and Technical Assistance Community Transition Goods and Services Skilled Nursing Nurse Delegation Private Duty Nursing Adult Day Health Respite Care Residential Habilitation Life Skills Wellness Education Personal Emergency Response System (PERS) Remote Observation and Care Equine Therapy Music Therapy Supported Parenting Vehicle Adaptations Staff/Family Consultation Community Inclusion Risk Assessment Peer Mentoring Community Engagement Specialized Clothing Supported Employment Services	**Older Adults, Adults with Disabilities, Individuals with MH/SUD** **Individuals with I/DD**

Other HCBS options (describe)		

Washington engages in extensive involvement with external partners. The demonstration and supplemental services are purposefully broad and are designed in accordance with these partners' feedback that services which are very narrowly defined are sometimes a barrier to care. This is especially evident in rural areas where resources are sometimes limited.

The care plans offered through RCL will encompass person-centered home and community-based services tailored to the circumstances and needs of individual participants. RCL care plans will be coordinated with allied systems including primary care, behavioral health (to include mental health and substance use disorder treatment services), vocational rehabilitation and housing.

Washington State's current transition system includes nursing facility case managers, residential case managers, DDA case managers, behavioral health community liaisons, and in-home Area Agency on Aging case managers. This system, however, focuses largely on transitioning individuals early in their institutional stay. Further, community feedback and national transition data highlight that some consumers with complex needs require intensive transition assistance.

E.2. MFP Demonstration services

E.2.1. Demonstration service description

MFP Demonstration services are qualified HCBS that could be provided, but are not currently provided, under the state or territory's Medicaid program. Demonstration services must be reasonable and necessary, not available to the participant through other means, and clearly specified in the participant's service plan. The state or territory is expected to test and evaluate Demonstration services. Demonstration services are not required to continue after the conclusion of the MFP Demonstration or for the participant at the end of the 365-day enrollment period. Demonstration service descriptions must include:

- The qualified HCBS Medicaid authority under which the service could be covered
- The target population(s) receiving the service
- For a new Demonstration service not currently covered under the state or territory's HCBS program, a description of the scope of the service including a definition of the discrete service; a complete list and description of any goods and services that will be provided; any conditions that apply to the provision of the service; and eligibility criteria
- For a Demonstration service currently authorized under the state or territory's Medicaid program, a description of how the service complements or supplements the authorized HCBS in an amount, frequency, scope, or duration greater than allowed under the state or territory's Medicaid program
- A description of how the state or territory will test and evaluate the service to determine whether the service contributes to the successful transition and community functioning of an MFP participant

The state or territory may insert information using (1) Example Table E.2.1, (2) a description in the text response box, or (3) a combination of both a table and a separate text description.

Example Table E.2.1. Demonstration services

Demonstration service title	HCBS Medicaid authority	MFP target population(s)	Amount, duration, and scope of service	Service testing and evaluation
Home Accessibility Modifications	1915 (c)	Older Adults, Physically Disabled Adults, I/DD, and these populations with Behavioral Health needs.	Home modifications necessary to enter/exit and maneuver in primary living spaces which are not covered by Medicaid, Medicare, or other insurance. This service, when authorized within the waiver, is only available to individuals who are residing in apartments or own homes and is limited to a $700 benefit limit. Under the MFP Demonstration, this service can be authorized to support pre-transition activities for those moving from and MFP qualified institution to an MFP qualified community setting, and during the demonstration year, if needed. The service benefit limit is $5000.	The MFP Policy team conducts an annual review of service utilization, expenditure and cost analysis to determine savings or budget neutrality.
Payment for one-time Services to support Transitions to Community Settings or stabilization in demo year: 1. One time Cleaning 2. Pest Eradication 3. Packing and Moving Services	1915 (c) 1915 (k)	Older Adults, Physically Disabled Adults, I/DD, and these populations with Behavioral Health needs.	The MFP program shall cover one time or short-term payment for demonstration services and activities to prepare an MFP participant's relocation from an MFP qualified institutional setting to a home and community-based setting. This service, when authorized within 1915 (k), is only available to individuals who are transitioning to a HCBS setting within 30 days of a CFC approved institutional discharge and is a maximum benefit, when combined with Community transition goods of $2500. Under a 1915 c waiver, the benefit limit is $850 and limited to those moving from a licensed residential setting to independent living. Under the MFP Demonstration, this service can be authorized to support pre-transition activities for those moving from an MFP qualified institution to a community setting, and during the demonstration year, if needed. The service benefit limit is $5000.	The MFP Policy team conducts an annual review of service utilization, expenditure and cost analysis to determine savings or budget neutrality.

Payment for securing a community-based home 1. Utility Deposits 2. Move In Deposits to include 1st Month's Rent, if necessary 3. Essential Household Goods/Items	1915 (c) 1915 (k)	Older Adults, Physically Disabled Adults, I/DD, and these populations with Behavioral Health needs.	The MFP program shall cover one time or short-term payment for demonstration services and activities to prepare an MFP participant's relocation from an MFP qualified institutional setting to a home and community-based setting. This service, when authorized within the 1915 (k), is only available to individuals who are transitioning to a HCBS setting within 30 days of a CFC approved institutional discharge and is a maximum benefit, when combined with Community transition goods, also known as Essential Household goods/items, of $2500. Under a 1915 c waiver, the benefit limit is $850 and limited to those moving from a licensed residential setting to independent living. Under the MFP Demonstration, this service can be authorized to support pre-transition activities for those moving from an MFP qualified institution to a community setting, and during the demonstration year, if needed. The service benefit limit is $5000.	The MFP Policy team conducts an annual review of service utilization, expenditure and cost analysis to determine savings or budget neutrality. See Supplemental Pre-Transition Service Descriptions detail with Essential Household goods/items checklist below table E.3.1

Not applicable.

E.3. MFP supplemental services

E.3.1. Supplemental service descriptions

Supplemental services are one-time services to support an MFP participant's transition that are otherwise not allowable under the Medicaid program. Supplemental services must be reasonable and necessary, not available to the participant through other means, and clearly specified in the participant's service plan. Supplemental services are not required to continue after the conclusion of the MFP Demonstration or for the participant at the end of the 365-day enrollment period. The state or territory is expected to test and evaluate supplemental services. Supplemental service descriptions must include:

- The target population(s) receiving the service
- The category of the supplemental service (short-term housing assistance, food security, payment for activities prior to transitioning from an MFP-qualified inpatient facility, payment for securing a community-based home)
- The scope of the service, including a definition of the discrete service (for example, if providing payment for activities prior to transitioning from an MFP-qualified inpatient facility, describe each discrete activity under this category, such as home accessibility modifications, vehicle adaptations, and home cleaning)
- An assurance that services are responsive to a person's needs and wants described in a person-centered plan
- A complete list and description of any goods and services that will be provided

- Any conditions that apply to the provision of the service
- How the state or territory will test and evaluate the service to determine whether the service contributes to the successful transition and community functioning of an MFP participant
- Under the payment for activities prior to transitioning from an MFP-qualified inpatient facility, please include the following information for each discrete activity:
  - Specify the time period for when payment to a provider for rendering the supplemental service will occur (e.g., up to 15 days prior to discharge/transition to the community date)
  - Specify the time period for when the service will be rendered (e.g., up to 15 days prior to discharge/transition date)

The state or territory must insert information using Example Table E.3.1 and may provide additional information in the text response box below.

Example Table E.3.1. Description of supplemental services

Supplemental service	Target population(s)	Amount, duration, and scope of service	Goods and services provided	Responsiveness to person-centered plan
Short-term Rental Assistance Housing Plan (separate entry required in E.3.2) 1. Six-month rental assistance (with utilities as needed)	Older Adults, Physically Disabled Adults, and these populations with Behavioral Health needs.	Limit of 6 months of short-term rental assistance. Total budget included in annual Supplemental Budget Request.	Please see Housing Plan in E.4.2	Please see Housing Plan in E.3.2
Food security Food Security Plan (separate entry required in E.3.2) 1. One Time Pantry Stocking	I/DD, Older Adults, Physically Disabled Adults, and these populations with Behavioral Health needs.	One-time benefit limit of $500 to be used towards the purchase of pantry items and fresh foods for those moving to independent living/In Home settings. Excluded from this benefit are those MFP participants who would be transitioning to a licensed residential setting.	Essential pantry and fresh food items ready and available for the individual upon their transition to their community home protects and promotes the health, safety and community stabilization of the individual.	Please see Food Security Plan in E.3.2

Supplemental service	Target population(s)	Amount, duration, and scope of service	Goods and services provided	Responsiveness to person-centered plan
Payment for activities which support transitioning from an MFP-qualified inpatient facility, and sustaining community living 1. In-Home General Utility or Repairs Allowance 2. Credit Counseling 3. Digital Literacy Skill Building	I/DD, Older Adults, Physically Disabled Adults, and these populations with Behavioral Health needs.	If necessary to facilitate an eligible individual's transition to the community, MFP supplemental services will allow for these services to be rendered for up to 180 days prior to transition. Payment to a provider for rendering the supplemental services will occur upon completion of the service.	The MFP program shall cover one time or short-term payment for supplemental services and activities to prepare an MFP participant's relocation from an MFP qualified institutional setting to a home and community-based setting.	See Supplemental Pre-Transition Service Descriptions below table E.3.1
Payment for securing a community-based home: Internet Setup and Hardware Access 1. Utility Deposits to enable Internet Access and services 2. Internet Routers and Wi-Fi Systems	I/DD, Older Adults, Physically Disabled Adults, and these populations with Behavioral Health needs.	This service provides **i**nternet installation, setup, and essential hardware (such as modems, routers, or related equipment) to support individuals transitioning from institutional settings into MFP-qualified community settings. Ongoing monthly service fees are not included; the focus is on removing barriers to initial access.	The MFP program shall cover one time or short-term payment for supplemental services and activities to prepare an MFP participant's relocation from an MFP qualified institutional setting to a home and community-based setting.	See Supplemental Pre-Transition Service Descriptions below table E.3.1

Supplemental service	Target population(s)	Amount, duration, and scope of service	Goods and services provided	Responsiveness to person-centered plan
Community Choice Guiding	Older Adults, Physically Disabled Adults, and these populations with Behavioral Health needs.	The tasks performed by the Community Choice Guide are person-centered and depend on the intensity of the participant's needs and the necessity for longer, more in-depth involvement for a successful transition. MFP supplemental services will allow these services to be rendered for up to 180 days prior to transition.	The Community Choice Guide assists with time-consuming components of the transition plan for participants with complex needs. At the authorization of the case manager, this could include coordinating the completion of other authorized services (Qualified, Demonstration or Supplemental) to support transitions and sustainability of community living. Under the waiver, this service is limited to 90 days and offered in HCBS settings only. When the service is provided in a community setting, it is offered as a Qualified service.	The MFP Policy team conducts an annual review of service utilization, expenditure and cost analysis to determine savings or budget neutrality. This service was added to the 1915 (c) Waiver in 2018 for those residing in a HCBS setting.

Supplemental service	Target population(s)	Amount, duration, and scope of service	Goods and services provided	Responsiveness to person-centered plan
Durable Medical Equipment/Specialized Equipment and Supplies	Older Adults, Physically Disabled Adults, I/DD, and these populations with Behavioral Health needs.	Under MFP Supplemental Services, this service will be authorized up to 180 days prior to discharge to support pre-transition planning, The service benefit limit is $5000.	Medical equipment and supplies necessary to live independently that is not covered by Medicaid, Medicare, or other insurance. This service, when authorized within the waiver, is only available to individuals who are residing in HCBS settings and are limited to a $700 benefit limit. During the demonstration year, this service is available under qualified services.	The MFP Policy team conducts an annual review of service utilization, expenditure and cost analysis to determine savings or budget neutrality.
Non-Medical Transportation	I/DD, Older Adults, Physically Disabled Adults, and these populations with Behavioral Health needs.	Round trip non-medical transportation is offered to MFP enrolled participants prior to transition from an MFP approved institution to tour prospective community living settings and to support community integration activities, such as locating a church, food bank or banking institution in a prospective new community.	Transportation is provided to support transitions from institutional settings to community stabilization. Under the various waivers, this service is limited to travel to and from a waiver service to meet a therapeutic goal and can only be provided once the individual is residing in an HCBS setting. Under the MFP Demonstration, this service can be authorized to support pre-transition activities to obtain a community home.	The MFP Policy team conducts an annual review of service utilization, expenditure and cost analysis to determine savings or budget neutrality.

Supplemental service	Target population(s)	Amount, duration, and scope of service	Goods and services provided	Responsiveness to person-centered plan
Client Training-Medical and Non-Medical	I/DD, Older Adults, Physically Disabled Adults, and these populations with Behavioral Health needs.	The Client Support Training service is identified in the client's CARE assessment and if needed, specific training needs can be identified in a professional evaluation. MFP supplemental services will allow for these client training services to be rendered for up to 180 days prior to transition to a community setting and supports the clients transition towards a less restrictive setting. Trainings include, but are not limited to: Adjustment to a serious impairment, Maintenance or restoration of physical functioning, Self-management of chronic disease, Acquisition of skills to address minor depression, Development of skills to work with care providers including behavior management, and Self-management of health and well-being through use of actionable education materials.	Under a waiver program, this service is provided in accordance with a therapeutic goal outlined in the plan of care. The provider's credentials are the determinate for whether the service is medical or non-medical. For example, if a nurse is teaching a client how to use their diabetic medications, then Medical Client Training would be appropriate. This service within the waiver is limited to authorization in an HCBS setting only. Any continuation of services performed with the individual in their community setting would be allowed as an MFP qualified service under the demonstration.	The MFP Policy team conducts an annual review of service utilization, expenditure and cost analysis to determine savings or budget neutrality.

HCS: Behavior Support Consultation & Stabilization Services DDA: Life Skills Stabilization	Older Adults, Physically Disabled Adults, and these populations with Behavioral Health needs. I/DD	Behavior Support Consultation and stabilization services/Life Skills Stabilization services may be provided for up to 180 days prior to transition from an MFP-qualified institutional setting. Services are time-limited supports designed to ensure the participant's health and safety during transition planning. This service provides specialized outreach and technical assistance for individuals who are preparing to transition into community-based settings. Supports are flexible and would begin while the individual is admitted to an approved MFP institutional setting, though could occur in the participant's prospective community home, or common community environments such as stores, offices, or parks to prepare and support the client for their transition. Behavior support strategies are individualized, coordinated, and non-restrictive, designed to reduce barriers to transition, decrease discharge wait times, and ensure participants can maintain safety in community settings.	Under the Waiver, services begin with a comprehensive behavioral assessment conducted by a Behavior Specialist to identify causes, triggers, and functions of challenging behaviors. Within 30 days, the provider develops a behavior support plan for the case manager that includes strategies to improve quality of life and address underlying physical, cognitive, or mental health conditions. The plan includes individualized, measurable interventions to reduce disruptive behaviors and promote positive functioning and direct interventions with the participant and supports to practice new skills in community settings. The plan provides guidance for caregivers and natural supports to ensure consistent approaches across environments and recommendations for behavioral health treatment and referrals to community	The MFP Policy team conducts an annual review of service utilization, expenditure and cost analysis to determine savings or budget neutrality.

Supplemental service	Target population(s)	Amount, duration, and scope of service	Goods and services provided	Responsiveness to person-centered plan
			providers, as needed. Any continuity of services after community transition would be available under MFP qualified services. These services are limited to 6 months in a community setting.	
Assistive Technology 1. Goods/Devices 2. Technology Support Consultation and Technical Assistance 3. Smart Care Device	Older Adults, Physically Disabled Adults, I/DD and these populations with Behavioral Health needs.	MFP supplemental services will allow for these services to be rendered for up to 180 days prior to transition. Under MFP participants can receive up to $5000 in Assistive Technology Devices, and Technology Support services prior to their transition to a community setting.	Adaptive devices or assistive equipment that increase independence or substitutes for human assistance, specifically with personal care, household, or health related tasks. Under the Community First Choice 1915 K plan, this service is authorized for up to $550 per fiscal year.	The MFP Policy team conducts an annual review of service utilization, expenditure and cost analysis to determine savings or budget neutrality. Technology Support Consultation/Technical Assistance and Smart Care Devices were added to the 1915 (k) Assistive Technology service package in 2026.

Supplemental service	Target population(s)	Amount, duration, and scope of service	Goods and services provided	Responsiveness to person-centered plan
Vehicle Adaptations	I/DD	MFP Supplemental services participants can receive up to $15000 in vehicle modifications prior to transition from an MFP Qualified setting which are needed to accommodate the unique needs of the individual, to enable full integration into the community,	Changes to a vehicle that are required and ensure the health, welfare, and safety of the participant and/or caregivers. Under the waiver, this service is authorized once the client is in a HCBS setting and the benefit limit is $4680. Under MFP, Vehicle adaptations performed prior to transition would decrease discharge wait times and ensure participants can remain safely in MFP-qualified community settings and get to medical and non-medical appointments in their communities. Any continuity of services after community transition would be available under MFP qualified services.	The MFP Policy team conducts an annual review of service utilization, expenditure and cost analysis to determine savings or budget neutrality.

Supplemental service	Target population(s)	Amount, duration, and scope of service	Goods and services provided	Responsiveness to person-centered plan
Payment for one-time Services to support Transitions to Community Settings or stabilization to in demo year: 4. One time Cleaning 5. Pest Eradication 6. Packing and Moving Services	Older Adults, Physically Disabled Adults, I/DD, and these populations with Behavioral Health needs.	The MFP Supplemental Services provide one time or short-term funding for services and activities to stabilize an MFP participant's qualified community setting while they are during their demonstration year. These services may also be used, when necessary, to support a participant's transition/move to a subsequent accessible in home-setting. The service benefit limit is $5000.	This service, when authorized within the 1915 (k), is only available to individuals who are transitioning to a HCBS setting within 30 days of a CFC approved institutional discharge and is a maximum benefit, when combined with Community transition goods of $2500. Under a 1915 c waiver, the benefit limit is $850 and limited to those moving from a licensed residential setting to independent living.	The MFP Policy team conducts an annual review of service utilization, expenditure and cost analysis to determine savings or budget neutrality.

Supplemental service	Target population(s)	Amount, duration, and scope of service	Goods and services provided	Responsiveness to person-centered plan
Payment for activities to secure a community-based home prior to transition: 1. Utility Deposits 2. Move In Deposits to include 1st Month's Rent, if necessary 3. Essential Household Goods/Items 4. Apartment Application Fees	Older Adults, Physically Disabled Adults, I/DD, and these populations with Behavioral Health needs.	The MFP Supplemental services shall cover one time payments for services and/or goods and activities to enable an MFP participant's relocation from an MFP qualified institutional setting to a subsequent home and community-based setting. These MFP supplemental services are paid for prior to transition but not earlier than 180 days prior to an individual's transition from an approved MFP institutional setting to facilitate a safe and effective transition. In addition, MFP supplemental services may be authorized when an individual is relocating from one in-home setting to another in-home setting as part of an approved community stabilization plan. In these cases, supplemental services support continuity, safety, and stability during the transition between community residences. The service benefit limit is $5000.	This service, when authorized within the 1915 (k), is only available to individuals who are transitioning to a HCBS setting within 30 days of a CFC approved institutional discharge and is a maximum benefit, when combined with Community transition goods, also known as Essential Household goods/items, of $2500. Under a 1915 c waiver, the benefit limit is $850 and limited to those moving from a licensed residential setting to independent living.	The MFP Policy team conducts an annual review of service utilization, expenditure and cost analysis to determine savings or budget neutrality. The list of essential household goods/items which may be considered can be found in the Supplemental Services approval document embedded below this table.

Supplemental service	Target population(s)	Amount, duration, and scope of service	Goods and services provided	Responsiveness to person-centered plan
Staff/Family Consultation	I/DD	MFP supplemental services will allow for these consultation services to be rendered for up to 180 days prior to transition. Staff and Family Consultation can include consultation on: • Health and medication monitoring • Positioning and transfer • Basic and advanced instructional techniques, • Augmentative communication systems • Diet and nutrition • Disability information and education • Strategies for effective interaction • Environmental consultation Under the MFP Demonstration, this service can be authorized to support pre-transition activities for those moving from a qualified MFP institution to a community setting,	This consultation assists family members, unpaid caregivers and/or paid support staff in carrying out an individual's treatment/support plans, which are necessary to improve the individual's independence and inclusion in their community. Consultations, such as assessment, development, and incorporation into a home or community support plan, is provided to families or direct staff to meet the specific needs of the participant. If a consultation occurs while in a community setting, will be available as an MFP Qualified service.	The MFP Policy team conducts an annual review of service utilization, expenditure and cost analysis to determine savings or budget neutrality.

Supplemental service	Target population(s)	Amount, duration, and scope of service	Goods and services provided	Responsiveness to person-centered plan
Community Inclusion	I/DD	MFP supplemental services will allow for these services to be rendered for up to 180 days prior to transition. This service can be authorized to support pre-transition activities for MFP participants of any age, moving from an MFP qualified institution to a community setting to support community integration.	Under the waiver, Community Inclusion is an individualized service that provides individuals with opportunities to engage in community based activities that support socialization, education, recreation and personal development for the purpose of: building and strengthening relationships with others in the local community who are not paid to be with the person and learning, practicing and applying skills that promote greater independence and inclusion in their community, but is limited to those aged 62 or greater. If the continued while in the community setting, will be available as an MFP Qualified service.	The MFP Policy team conducts an annual review of service utilization, expenditure and cost analysis to determine savings or budget neutrality.

Supplemental service	Target population(s)	Amount, duration, and scope of service	Goods and services provided	Responsiveness to person-centered plan
Risk Assessment	I/DD	MFP supplemental services will allow for these services to be rendered for up to 180 days prior to transition. This service can be authorized to support pre-transition assessment and person-centered care planning considerations for those moving from an MFP qualified institution to a community setting to support community integration.	Determines essential supports needed to ensure success in the community. Professional evaluations that assess the person's needs and their level of risk of sexual predatory behavior or aggression. The risk assessment is used to identify the least restrictive alternatives necessary to support the person in the community. If a subsequent risk assessment is needed while in the community setting, this is available as an MFP Qualified service.	The MFP Policy team conducts an annual review of service utilization, expenditure and cost analysis to determine savings or budget neutrality.

Supplemental service	Target population(s)	Amount, duration, and scope of service	Goods and services provided	Responsiveness to person-centered plan
Peer Mentoring	I/DD	Under the MFP Demonstration, this service can be authorized to participants of any age to support pre-transition activities for those moving from a qualified MFP institution to a community setting to support community integration,	Under a waiver, the services are limited to individuals residing in their family homes or for youth under 21. Peer mentoring provides in-person support and guidance to a client and family members of a client by a person with shared experience to increase opportunities for socialization, integration, personal growth of a person by connecting a waiver participant to community services, programs and resources and answer participant questions or suggest other sources of support to achieve the client's goals. If continued while in the community setting, will be available as an MFP Qualified service.	The MFP Policy team conducts an annual review of service utilization, expenditure and cost analysis to determine savings or budget neutrality.

Supplemental service	Target population(s)	Amount, duration, and scope of service	Goods and services provided	Responsiveness to person-centered plan
Community Engagement	I/DD	Under the MFP Demonstration, this service can be authorized to support pre-transition activities for those moving from a qualified MFP institution to a community setting to support community integration for six months.	Connects a participant to activities, resources, events, and other services in the community that the participant is interested in exploring. This service is intended to assist the participant with fully accessing their community and reducing social isolation. If continued while in the community setting, will be available as an MFP Qualified service.	The MFP Policy team conducts an annual review of service utilization, expenditure and cost analysis to determine savings or budget neutrality.
Specialized Clothing	I/DD	Under the MFP Demonstration, this service can be authorized while institutionalized to support pre-transition activities for those moving from a qualified MFP institution to a community setting.	Non-restrictive clothing adapted to the participant's individual needs and related to his/her disability. When specialized clothing is necessary during the demonstration year, it will be available as an MFP Qualified service. Examples of specialized clothing include compression shirts, clothing designed for wheelchair users or for those with a g-tube, shirts with magnets instead of buttons, etc.	The MFP Policy team conducts an annual review of service utilization, expenditure and cost analysis to determine savings or budget neutrality.

Supplemental service	Target population(s)	Amount, duration, and scope of service	Goods and services provided	Responsiveness to person-centered plan
Supported Employment Services	I/DD	Under the MFP Supplemental Service, this service can be authorized to support pre-transition activities for those moving from a qualified MFP institution to a community setting to support community integration for up to 180 days prior to transition.	Individual Employment or Group Supported Employment. These services support clients to pursue or maintain gainful employment in integrated settings in the community. Supported employment occurs in a variety of integrated business environments and include jobs paying a minimum wage or higher, support to obtain and maintain jobs, and promotion of career development and workplace diversity. When continued while in the community setting, will be available as an MFP Qualified service.	The MFP Policy team conducts an annual review of service utilization, expenditure and cost analysis to determine savings or budget neutrality.

Washington State received CMS approval to add Pre-Transition Activities and Payments for securing a Community Based Home into our Supplemental Services Package in March of 2023. Please see additional details on the duration and scope of these services.

WA State Supplemental Pre-Tr

Decisions to incorporate supplemental services in current waiver and State plan services during or after the conclusion of the MFP demonstration period will be made by collecting information about the following:

- overall cost analysis to determine savings or budget neutrality,
- frequency of particular service needs for this population under the MFP demonstration,

- determination of which services are essential to living in home and community-based settings; and
- incorporating questions into a state's survey tool specific to MFP supplemental services and into HCLA's service experience team meeting which is an advisory group comprised of HCBS service recipients including MFP participants.

We will then use this information to decide which policy level budget decisions to bring forward to legislators and the governor.

E.3.2. Supplemental services housing plan and food security plan

If providing short-term housing assistance or food pantry stocking, upload the required housing plan or food security plan that describes how these services will be administered and sustained. See the March 31, 2022 Note to MFP Recipients: Announcement of Certain Changes to Supplemental Services under the MFP Demonstration for specific requirements for the housing and food security plans.

Short-term Housing Assistance/Rental Subsidies:
Provides up to 6 months of short-term rental assistance and associated utility expenses to bridge the gap between transition to the community and when federal, state, or local housing assistance is secured. The housing plan is managed by HCLA and will service older and/or physically disabled adults. Washington State received CMS approval to add this into our Supplemental Services Package in March of 2023 and Short-Term Rental Assistance (STRA) services were rolled out in July of 2023. Please see additional details and plan in Section F. Transition and Housing Services, and below Supplemental Services Housing Plan.

WA State Supplemental Servic

Food security:
Provides food pantry stocking for up to a 30-day period for RCL participants. Case Managers will document in the CARE assessment the amount of food assistance available for the individual. This shall not exceed the maximum allowable amount of $500 per recipient.
The state leverages existing partnerships with food and nutritional assistance programs intended to maintain or improve the health status of these individuals, support their independence, prevent premature institutionalization and allow earlier discharge from hospitals, nursing homes, or other residential care facilities (such as Senior Farmers Market Nutrition Program, home delivered nutrition and congregate nutrition sites). This pantry stocking benefit fills the gap between an individual's transition from the institutional setting, the application, eligibility determination and issuance of food assistance co-managed with the Community Services Office (CSO) and strengthens food security for those who are interested in utilizing existing nutritional assistance programs but are unable to quickly access these programs. Washington State received CMS approval to add this into our Supplemental Services Package in March of 2023 and Pantry Stocking services were rolled out in July of 2023. Please see the below Supplemental Services Food Security Plan with an embedded pantry stocking checklist for approved pantry stocking items and exclusions.

WA State Supplemental Servic

E.4. Managed long-term services and supports

Select the box below to indicate whether your state or territory operates an MLTSS program.

☐ Yes, the state or territory operates an MLTSS program that includes providing HCBS to these populations: (select all that apply).

- ☐ Older adults
- ☐ Adults with PD
- ☐ Individuals with I/DD
- ☐ Individuals with MH/SUD
- ☐ Other, please specify (e.g., HIV/AIDS, brain injury)

For states or territories that selected "Yes", describe how the state or territory implements the MFP Demonstration under managed care programs. Clearly indicate the qualified HCBS, Demonstration, and supplemental services that are delivered under managed care. Additionally, describe how the MFP Demonstration supports or complements the state or territory's MLTSS strategy for expanding HCBS, promoting community integration, ensuring quality, and increasing efficiency.

Washington does not have an MLTSS Service delivery model for HCBS. All HCBS are Fee for Service.

E.5. Service providers

E.5.1. Qualified HCBS, MFP Demonstration, and supplemental service providers

For each qualified HCBS, MFP Demonstration, and supplemental service, include the following:

- Describe how the state or territory will ensure that providers have sufficient experience and training in the provision of their applicable supplemental services.
- Describe how the state or territory provides access to needed services or manages a waiting list when provider shortages or other barriers prevent timely provision of HCBS, MFP Demonstration, and supplemental services.
- Describe how the MFP program will ensure that MFP participants are offered the choice of a Medicaid-qualified provider under a person-centered planning process or the Medicaid authority limiting participants' choice of provider.

The state or territory may insert information using (1) Example Table E.5.1, (2) a description in the text response box, or (3) a combination of both a table and separate text description.

Example Table E.5.1. Describe HCBS, MFP Demonstration, and supplemental service provider qualifications

Service	Provider qualifications
See below	

HCLA contracts with 13 Area Agencies on Aging (AAA) to develop, maintain, and ensure a quality statewide Medicaid provider network to serve clients who are eligible for Medicaid long term services and

supports. The AAAs are required to maintain and distribute a list of all their contracted providers to case managers in their respective areas which are then referenced and provided to clients to choose from in their individualized person-centered care plan.

For any prospective service contract, applicants must meet the minimum qualifications to provide home and community-based services. AAA's recruit adequate service providers for Medicaid State Plan (Community First Choice, Medicaid Personal Care, etc.), Medicaid Waiver, and Roads to Community Living services in their area to allow access to all clients for needed services and where possible to provide clients with choice of provider. All provider qualifications for Medicaid Long-Term Services and Supports (LTSS) and scopes of work are established by HCLA and maintained on this website along with application materials: Information for Potential Medicaid Contractors. As a deliverable of the AAA and HCLA interlocal contract, the AAA must contract with all willing and qualified providers. If the AAA determines it is necessary to contract with a provider that does not meet the qualifications, the AAA must receive prior written approval from HCLA. The AAA cannot waive professional licensing or certification qualifications. When reviewing applications for Medicaid services, AAAs must evaluate provider applications only against the qualifications published by HCLA and state and federal guidelines. The review must be accomplished in a consistent, objective manner. If a provider is determined not qualified, the AAAs must document the basis for its decision, including consultation with other AAAs which may have reached a different decision regarding that applicant. The AAA must notify HCLA if a provider deemed not qualified is contracted with another AAA to provide the same service and the AAA must notify the provider of its decision and the appeal process.

The State has a highly developed provider contract monitoring system as outlined in section I of this operational protocol. This includes monitoring a statistically valid sample of existing providers to assure that qualifications continue to be met. Washington re-verifies licensing or certification at the time of contract renewal and per individual licensing or certification schedule. If licensing and/or certification is not required, the State monitors based on qualifications in approved waivers and the State plan. We will use the existing system for providers under RCL.

If the provider does not maintain or meet qualifications, appropriate action is taken to rectify the situation at the time of contract monitoring and renewal of the contract. This may include termination of the contract, if qualifications cannot be met.

As the number of contracted providers increases, the need for systemic change in our contracting procedures and quality assurance also increases. Early in the demonstration, positions were created specifically to manage the systemic issues that arise as we bring providers in through a network of complicated individual, agency, city, county, and State contracts. These positions are called Resource Support & Development specialists, and they work to support prospective providers through the application process, as well as identify and strengthen our statewide network capacity. As mentioned earlier in this section, our community client services contracts are primarily handled through our AAAs, however, providers which can provide client services on a statewide level are managed by HCLA HQ. The RCL DQA and the Project Director analyze, review and make recommendations regarding policies and procedures to determine best practices for RCL client service provider contracts acquisition, contracted provider capacity and rates determination.

E.6. Other information

If needed, provide other information regarding the state or territory's benefits and services that is not addressed elsewhere in the template.

Not applicable.

SECTION F. TRANSITION AND HOUSING SERVICES

F.1. Transition services

F.1.1. Comprehensive transition coordination services

Describe how the state or territory's MFP Demonstration will implement comprehensive transition coordination services during these three phases: (1) pre-transition, (2) transition, and (3) during an MFP participant's 365-day enrollment period. Include the following:

- Description of transition coordination activities
- Description of person-centered planning in the transition coordination process, including:
  - How the state or territory's MFP Demonstration will ensure that each MFP participant's service plan is individualized to provide the services and supports needed to live in the community
  - How MFP participants and their legally authorized representative (if applicable) will lead the development of their service plan
- Steps in the transition coordination process
- Communication process between MFP transition coordination and Medicaid HCBS programs
- How transition coordination services advance health for all people served
- How transition coordination services promote community integration

Use discrete descriptions for each target population.

Home and Community Services:

Home and Community Services (HCS) provides comprehensive transition coordination services to older adults, disabled adults, and individuals with mental illness to support a client throughout pre-transition, transition, and during an RCL participant's 365-day demonstration period. HCS case managers are designated to each Medicaid certified nursing facility and other qualified institutional settings across the state. The facility assignment fosters strong connections with facility staff and clients, creating early engagement opportunities for transition planning. In addition, Nursing Facility Case Managers utilize the Minimum Data Set (MDS) Acuity report to aid in identifying individuals who have lower acuity and may be ready to transition to a lower level of care. As case managers meet and identify clients who are interested in transition planning, the case manager will complete a Comprehensive Assessment Resident and Evaluation (CARE) with the client. This standardized assessment process always includes a face-to-face interview with the client, family, legal decision maker (if applicable), and others of the client's choosing. Through this process, they collaboratively gather and document essential information, including needs, goals, strengths, limitations, resources, preferences, and level of care requirements. Based upon policy outlined in HCLA's Long-Term Care (LTC) Manual, Chapter 3, the assessment process leads to the development of a person-centered plan of care encompassing services needed by the client while determining availability of informal supports and other non-department paid resources and community resources. Informal supports are any resources available to fully or partially complete individual Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL) tasks identified in the client's care plan. Identified informal supports are based on voluntary action and are available so long as the source is willing and able to continue them. The plan of care includes the client's choice of living situation, what services the individual is eligible for, limits on authorized hours, and any additional supports needed as identified in the assessment. The individual and/or their legal decision maker signs and receives a copy of their person-centered plan of care. To support the individual's transition plan, the assigned case manager authorizes any services and supports that can be utilized throughout the transition process.

Case managers coordinate with the client, facility staff, MCO, contracted providers, and other community partners to ensure the client's needs are met upon transition to an HCBS setting. The assigned case manager will authorize services and supports to implement the transition plan.

The same case manager remains assigned through the transition and for a period after the transition to ensure continuity of services and supports. During the transition, the case manager is consistently communicating with the client and care team to help ensure services and supports are in place. As transition occurs, previously unidentified needs sometimes arise, and the case manager may need to authorize additional services to stabilize the transition. To ensure the continuity in case management, case transfer policy as outlined in the LTC Manual, Chapter 5 is followed statewide to determine when the case is ready to transfer to another case manager who is assigned the specific setting in which the client has transitioned to. Cases undergo supervisory review at transition points to ensure continuity and completeness. Before a case transfer, the transferring case manager's supervisor conducts a review to confirm all necessary steps have been completed. Upon transfer, the receiving case manager's supervisor also reviews the case for accuracy and readiness. The receiving case manager will continue to provide case management through the 365-day demonstration period unless the client changes settings or is reinstitutionalized. The case manager will visit and assess the client annually or sooner based on client's care needs, cognition, emotional/psychiatric/behavioral needs, and support system. This provides an opportunity for the case manager to ensure the client is receiving all the services and supports that may assist the client in remaining stable in the community. The case manager has the option to complete a significant change assessment anytime to assess changes in client condition so the plan of care can be revised to reflect updates in care tasks and caregiver instructions. This may also trigger additional referrals for services that could be authorized to help the client remain stable in the community.

The Home and Community Services MFP team maintains ongoing communication and collaboration with other Medicaid HCBS programs. Strong relationships with other program managers are essential to ensuring a smooth transition for MFP participants as they move to another program after completing their 365-day demonstration period. This coordination not only allows for training on MFP operations but also facilitates the sharing of lessons learned and the integration of services into waivers and state plans. Additionally, these discussions help identify service gaps and explore potential pilot programs that MFP can implement to address unmet needs within the state.

As MFP participants approach the end of their 365-day demonstration period, the CARE tool sends alerts to the assigned case manager. Alerts assist in prompting the case manager to begin coordinating with the designated HCS Public Benefits Specialist, if necessary, to ensure the client can seamlessly transition to another HCBS program without interruption to their services and supports.

The transition coordination services advance health for all people served by ensuring they receive the right support at the right time. Importantly, several transition services can be accessed before an individual moves, helping to ensure that their next setting is safe, stable, and fully prepared to meet their needs. By providing essential services such as home modifications, general utility repairs, behavior support consultation, technical support consultation and technical assistance, pantry stocking, and short-term rental assistance, we address safety, accessibility, nutrition, and housing stability. These pre-transition services not only improve well-being but can also facilitate earlier discharges and reduce the likelihood of long-term institutionalization. Developing a client-centered plan and honoring client choice empowers individuals to determine which supports best align with their needs and goals.

Additionally, as part of HCLA's Strategic Plan and Performance Metrics, we track key data related to nursing facility transitions and evaluate opportunities for improvement. Key data includes the number of individuals who transition to home and community-based settings from nursing homes, the percentage of clients who remain in the community without reinstitutionalization within the first 30 days of transition, and the average length of time an individual remains in the community setting after their nursing facility transition.

Transition coordination services promote community integration by equipping individuals with the skills, resources, and support needed to navigate and engage with their surroundings confidently. Through the client training service, individuals can develop essential skills ranging from management of medical conditions to independent living skills which empowers them to participate more fully in their communities. Community Choice Guides provide hands-on support to help individuals explore and access local resources, fostering greater familiarity and comfort with community settings. Innovative services such as remote caregiving and Smart Care Companion offer alternative models of support that enhance safety, reduce isolation, and provide real-time engagement, all while respecting an individual's autonomy. These technologies not only offer practical assistance, such as reminders and monitoring personal care tasks, but also contribute to social connectedness, which is a key factor in successful community integration. Additionally, technology support consultation and technical assistance ensure that individuals can effectively utilize assistive technology to enhance their independence and engagement. By providing tailored supports based on a person-centered plan, transition coordination services empower individuals to live with greater confidence, security, and connection which allows them to fully participate in and contribute to their communities.

Developmental Disabilities Administration (DDA)

Developmental Disabilities Administration (DDA) provides comprehensive transition coordination services for individuals with qualifying developmental disabilities originating before age 18. These may include intellectual disabilities, cerebral palsy, epilepsy, autism, or other neurological conditions closely related to intellectual disability that require similar support.

For DDA, transition coordination encompasses all stages: preparation, active coordination, and post-move stability. The process is guided by DDA Policy 3.03 Transitional Care Management.

Transition Coordination Process: Upon enrollment in Money Follows the Person (MFP), individuals transitioning from institutions to community-based settings are assigned an experienced Transition Case Manager. These managers specialize in supporting such moves and remain involved throughout pre-transition, transition, and the entire 365-day MFP-RCL demonstration period. They are assigned by geographic region to ensure familiarity with local resources, institutional settings, and residential service providers.

The first step after enrollment is a face-to-face interview with the individual, their family, legal decision maker (if applicable), and others the individual wishes to include. This collaborative process gathers essential information about the person's needs, goals, strengths, limitations, resources, preferences, and level of care requirements.

Person-Centered Planning Tools: DDA prioritizes a person-centered approach. Once enrolled in MFP-RCL, the Transition Case Manager initiates person-centered planning using one or more of the following tools:

- The MyPage Profile: A one-page profile completed before the initial assessment and transition meeting. It helps the case manager understand what is important to the individual, covering topics such as strengths, skills, interests, a "perfect day," preferred living situation, cultural or spiritual needs, and relationships. Individuals can complete this independently or with assistance from a trusted person facilitated by the case manager.

  My Page Profile.pdf

- Transition Social Story – "Transitioning to a New Home": An illustrated, interactive tool that explains what to expect during the move from an institution to the community. It covers daily routines, personal goals, important information for service providers, preferred activities and

supports, and individuals involved in planning meetings. Like the MyPage Profile, individuals may complete this independently or with assistance.

- Formal Person-Centered Plan: Developed using frameworks such as John O'Brien's Lifestyle Planning, PATH, or Michael Smull's Essential Lifestyle Planning. Individuals choose who participates in planning meetings, resulting in a documented plan with specific goals reflecting their priorities.
- These tools help engage individuals in discussing their vision for their move, what matters most to them, and how they wish to be involved in planning.

Assessment and Service Planning: The Transition Case Manager provides expertise on the moving process and explores the individual's ideal living situation and community preferences, skills, interests, and employment goals, desired housemate characteristics, recreational, social, cultural, and spiritual activities, important connections with friends and family, preferred daily schedule, plans for pets accompanying the move, available services and alternative program options.

The same case manager conducts a Comprehensive Assessment Reporting Evaluation (CARE) assessment to document functional abilities, determine eligibility for long-term care services, evaluate assistance needs, and develop a person-centered plan of care. This plan includes chosen living arrangements, eligible services, authorized service hours, additional supports identified through the assessment.

The individual and/or their legal decision maker signs and receives a copy of the plan. The case manager coordinates authorization of services and collaborates with facility staff, Managed Care Organizations (MCOs), contracted providers, and other community partners to ensure a seamless transition to Home and Community-Based Services (HCBS).

A key outcome of the CARE assessment is the Person-Centered Service Plan (PCSP), a written document outlining the individual's needs, goals, and preferences, developed collaboratively with the individual and their support network. The PCSP is central to services provided by DDA, ensuring the individual's voice guides service delivery.

Active Coordination of Transition: Once a transitioning individual and a residential provider reach mutual agreement, the active transition coordination phase begins. The Transition Case Manager and the DDA support team identify participants for the initial transition meeting, typically held within five working days of agreement on a specific move location. The Transition Coordination Team—comprising individuals who play key roles in implementing supports—meets regularly to identify medical and behavioral referral needs, develop support plans tailored to the individual's needs and preferences and address issues critical for a successful transition

Throughout the transition, the case manager maintains frequent communication with the individual and the coordination team. As transitions progress, new needs may arise, prompting the case manager to authorize additional services to ensure stability.

Post-Transition Support: The Transition Case Manager continues to provide case management throughout the 365-day demonstration period, even if the individual changes settings or is temporarily reinstitutionalized. Regular check-ins—both in-person and virtual—are conducted to assess the individual's adjustment and ensure they are receiving appropriate services. At least one in-person visit is required within the first 30 days post-transition to confirm the individual's stability and access to necessary supports.

At the conclusion of the 365-day demonstration period, every DDA MFP-RCL participant is guaranteed a waiver slot, ensuring uninterrupted services. To support this transition, DDA headquarters maintains close communication with the DDA waiver unit and collaborates with other program managers to facilitate smooth transitions between programs, identify service gaps, explore pilot initiatives to address unmet needs statewide

As participants approach the end of the demonstration period, the CARE system issues alerts to prompt case managers to coordinate with the designated Public Benefits Specialist, ensuring seamless transfer to ongoing HCBS programs without service disruption.

Impact of Transition Coordination Services: DDA transition coordination services advance health equity by ensuring individuals receive the right supports at the right time. Critically, many services are available before the move to ensure the new setting is safe, stable, and fully prepared. These pre-transition services include home modifications, general utility repairs, behavioral support consultation, technical support and technical assistance, and one time pantry stocking. Such services enhance safety, accessibility, and nutrition, reducing institutionalization risks and enabling earlier discharges.

Like HCS, DDA transition coordination promotes community integration by equipping individuals with skills, resources, and confidence to engage meaningfully with their communities. Through supports delivered by community residential providers, individuals develop abilities ranging from medical management to independent living skills, empowering them to participate fully in community life. Person-centered planning ensures supports are tailored to each individual's unique goals, enabling greater independence, security, and connection.

F.1.2. Transitions under managed care plans

If MFP participants are required to enroll in a managed long-term care or comprehensive managed care plan, clearly describe how the MFP Demonstration will coordinate the delivery of comprehensive transition coordination services with the MCP. Include the following:

- Describe the roles and responsibilities for the MCP during each transition phase: (1) pre-transition, (2) transition phase, and (3) during an MFP participant's 365-day enrollment period
- Describe how the MFP program will ensure that MCPs provide all data and related documentation necessary to monitor and evaluate MFP transition coordination services, including identifying MFP managed care encounters through the Transformed Medicaid Statistical Information System (T-MSIS).

Managed care plans do not have any roles and responsibilities in home and community-based service delivery or project administration of MFP in Washington State. Health Care Authority contracts with managed care plans who are responsible for the full scope of Medicaid physical, mental, and substance use disorder services. This includes outpatient care, pharmacy and laboratory services, inpatient hospital and emergency room services, skilled rehabilitation only in nursing facilities, and outpatient mental health. Managed Care Plans (MCP) are involved in pre-transition phase as requested and may participate in care conferences and interdisciplinary team meetings for hospitalized clients.

F.1.3. Housing-related services and supports

Describe how the state or territory will structure, organize, and implement housing-related supports and services to increase affordable and accessible housing opportunities for MFP participants. Account for any differences between target population groups and geographic service areas, specifically in rural service areas.

Home and Community Services:

As part of the person-centered plan of care, individuals will identify their own needs and desires for housing. During this process, if a client had housing prior to institutionalization, efforts will be made to sustain that housing for the client to return to. If housing has been lost or the client did not have housing previously, assigned case managers can authorize contracted service providers (Community Choice Guides) to assist clients in the process of exploring housing options in the area they want to live.

The Office of Housing and Employment (OHAE) is focused on developing and administering housing resources to individuals who are being served with Long-Term Services and Supports (LTSS), including those who are MFP eligible.

OHAE has partnerships and contracts with Public Housing Authorities, state agencies such as the Department of Commerce and the Health Care Authority, local housing agencies, property owners and developers. Washington strives to continuously add resources to expand capacity for independent, affordable housing statewide.

A state resource called the HCLA Subsidy has been developed which serves to transition individuals from institutional settings into the community using state funds when a federally funded housing resource is not available. We have long been utilizing MFP services to support these transitions and are now able to integrate the MFP Short-Term Rental Assistance (STRA) into our benefit portfolio. We have aligned MFP STRA eligibility with the eligibility for our existing HCLA subsidy. By structuring the benefit in this way, MFP participants have access to rental assistance beyond the sixth month limit for MFP and until a permanent housing resource is found. Other services provided to MFP eligible individuals include interim housing and eviction prevention. OHAE has also worked to leverage Supportive Housing and Supported Employment benefits via Washington's 1115 Waiver to provide additional support for MFP participants. Additional information on the MFP Short-Term Rental Assistance is in the Housing Plan Section E.3.

DDA:
Individuals receiving services through DDA may live in homes that they rent or own, with agencies providing the level of needed support (Supported Living). Individuals receiving services from DDA also have the option of companion homes (one person living with a provider); alternative living – habilitation services in own home; or supports in the family home by an individual or an agency.

For DDA, 1 full-time Program Manager and 2 full-time housing specialists work to find homes for DDA clients. Both housing specialists primarily work with clients residing in the State Operated Living Alternative (SOLA) which is a state-employee-staffed setting. The Accessible/Affordable Housing Program Manager works on housing project initiatives and explores funding sources to create and sustain affordable housing for DDA clients. All 3 positions have proven to be essential because of Washington's tight housing market as they support clients moving from institutions to homes in the community.
DDA has a "set-aside" in the State Housing Trust Fund every biennium. These funds are made available to non-profit housing builders who identify individuals with developmental disabilities in need. DDA staff will make sure that people leaving the institutions are aware of this opportunity for housing.

RCL services offer strong incentives to those providers with accessible and affordable housing that eligible individuals need to relocate in communities throughout Washington State. DDA will continue to work with the Housing Trust Fund to set goals for availability of Housing Trust Fund dollars to RCL participants.

Select the following housing-related services and supports available to MFP participants. See the State Health Official letter #21-001 RE: Opportunities in Medicaid and CHIP to Address Social Determinants of Health (SDOH) for a description of housing-related services and supports.

☒ Home accessibility modifications (provide a dollar amount available per participant)

$5,000, General Utility and Repair Allowance $5000

☒ One-time community transition costs (provide a dollar amount available per participant)

$5,000 Community Transition goods, $5,000 Community Transition services

☒ Pre-tenancy supports

Click or tap here to enter text.

☒ Tenancy supports

Click or tap here to enter text.

F.2. Partnerships with state or territory and local housing entities

Describe how the state or territory will develop and sustain partnerships with state or territory and local housing agencies to increase access to affordable and accessible housing for MFP participants. Include the following:

- How the state or territory will put in place partnership arrangements with state or territory and local housing entities
- How the state or territory will work with those entities to assist MFP participants to obtain affordable and accessible housing
- Description of the proposed infrastructure expenditures to support housing partnerships; examples of infrastructure expenditures include:
  - Housing specialist position(s)—responsible for developing/maintaining system-level partnerships with state or territory and local housing entities
  - Technology—for example, electronic referral systems, shared data platforms, screening tool, case management systems, databases/data warehouses, housing registry
  - Workforce development—for example, training, housing coordination certification, cultural competency training
  - Outreach, education, and convenings—for example, design and production of outreach and education materials, translation, investments in community convenings

HCS's Office of Housing and Employment (OHAE) currently contracts with nine WA Public Housing Authorities to provide direct referrals for federally funded Housing Choice, Mainstream, and Non-Elderly Disabled vouchers and units subsidized with federal 202 funds.

We hold a contract with the WA State Department of Commerce to provide direct referrals to the federal 811 Project Based Units across WA.

- Through a contract with Spokane Housing Authority (SHA), the HCLA Subsidy, modeled after a federal Housing Choice Voucher, is administered statewide. SHA holds interlocal agreements with all other PHAs in WA to operate in their service areas and to provide National Standards for the Physical Inspection of Real Estate (NSPIRE) inspections. The duties of SHA include:
- Processing of HCLA subsidy applications and issuance of vouchers for the area the client chooses to search for housing.
- Processing of Request for Tenancy Approval (RFTA) to determine eligibility of a unit to receive the subsidy. This includes calculating rent and utility amounts based on client income.
- Communication with landlords to coordinate subsidies, including collection of necessary documentation for Housing Assistance Payment (HAP) contracts, which enables SHA to pay the subsidy to landlords directly. Subsidy recipients are responsible for paying the tenant share to the landlord.
- Processing Annual Recertifications to determine continued eligibility of subsidy and review rent amounts based on FMR (Fair Market Rent) and client income.

- Monthly reconciliation and invoicing for subsidy payment from HCLA to pay landlords.

We contract with selected developments for set-aside HCLA subsidy units which are modeled after Project Based Vouchers. As our inventory of these grow, we can provide units to individuals exiting institutions with a more efficient pathway to housing by eliminating the housing search.

We continue to have a growing set of informal partnerships where local landlords and property managers directly inform us when they have units of affordable housing available.

The Office of Housing and Employment (OHAE) provides direct technical assistance and support to housing agencies through trainings and materials, regular meetings and a single point of contact for referrals and other issues. The Office consists of a team of dedicated subject matter experts at the intersection of HCLA Long-term Services and Supports and affordable, independent housing. OHAE staff directly support housing applications and move-ins by acting as liaisons between housing agencies, regional case management and contracted housing providers.

A specific goal of OHAE is to increase capacity to meet the growing need of affordable housing. A Housing Capacity Program Manager increases access to additional housing resources (subsidies, vouchers) which will enable diversity amongst the housing options.

OHAE coordinates support for interim or short-term subsidy recipients to apply for permanent federal voucher or waitlist opportunities when they are available. HCLA provides training and support to contracted providers, referred to as Community Choice Guides (CCGs) and Supportive Housing Providers (SHP), to work directly with MFP individuals to utilize available housing resources. These contracted providers can:

  - Support completing housing applications and other necessary paperwork
  - Support housing search and coordinate move-in activities
  - Provide support for community integration
  - Make payments on behalf of the client (move-in costs such as deposits and fees)
  - Purchase essential furnishings and household goods on behalf of the client
  - Assist in coordinating moving and packing services, deep cleaning, and/or pest eradication

The following positions are responsible for developing and maintaining system-level partnerships:

- OHAE is comprised of an Office Chief, Administrative Assistant and 4 Unit Managers overseeing 3 housing and 1 employment units.
- The housing units have 11 Program Managers who are divided regionally across the state to provide direct program support to case managers, state and local housing agencies, as well as contracted providers.
- OHAE has 6 program managers who provide statewide management for housing capacity, contracts and payments, training, regional case management support and special projects.

Though these positions are not funded by the MFP Demonstration, the Roads to Community Living policy unit coordinates closely with the OHAE Unit to coordinate short term rental assistance.

Most of our housing related resources, including referral forms (screening tool) and applications utilize a secure electronic format. We utilize shared data platforms for exchanging secured client data as well as

other data and tracking. OHAE utilizes the Comprehensive Assessment Reporting and Evaluation (CARE), Automated Client Eligibility System (ACES), Barcode (electronic client record), ProviderOne, Predictive Risk Intelligence System (PRISM) and the Consolidated Housing Assistance & Information (CHAI) database. CHAI was developed by and for OHAE with the support of our agency's IT department and a contracted IT specialist. OHAE created and manages housing dedicated webpages on the DSHS-HCLA website. This site provides regional staff, contracted providers, and the with information on HCLA housing resources.

In partnership with WA State Department of Commerce and the WA State Health Care Authority, the OHAE Supportive Housing unit collaborates to hold an annual Supportive Housing Symposium focused on providing training and information to the providers of supportive housing services. OHAE staff provide a variety of housing and LTSS trainings to our contracted providers. OHAE also contracts with local subject matter experts for additional training (e.g. Harm Reduction, housing law advocacy, Trauma Informed Care, etc.).

OHAE has program managers dedicated to creating and maintaining outreach and education materials, with the input of content from regional program managers, for all HCLA housing resources. We have many of these publications translated into multiple languages. This also includes the collaborative creation of trainings used by program managers to present to regional staff and contracted providers. Most OHAE staff provide outreach and training, up to the federal level, where we provide technical assistance and support to other states and agencies to integrate housing services into LTSS. WA HCLA staff were active core members of the first federal Housing and Services Partnership Accelerator (HSPA) put on by Health and Human Services (HHS) and Housing and Urban Development (HUD).

F.3. MFP-qualified residence

Describe how the state or territory will verify and document the type of MFP-qualified residence (see PTC 15) an MFP participant resides in during the 365-day enrollment period. Use discrete descriptions for each target population if applicable. Include the following:

- Description of the process for identifying MFP-qualified residences
- Description of the provider(s) responsible for verifying and documenting the type of MFP-qualified residence
- Assessments or tools for screening MFP-qualified residences, including:
  - Name and description of the assessments of tools
  - Embed any assessments or tools below or in the appendix, or provide a link to the source

Home and Community Services:

As part of the person-centered plan of care, each individual will identify their own needs and desires for housing. It is likely that after an institutional stay of at least 2 months, some people may have lost their housing. If not, efforts will be made to transition them back into the setting they left. For those instances where that is not the case, the housing resources vary greatly according to what geographic area they live in. See section F.2 for additional details on Housing Resources available through HCLA.

The RCL team meets regularly with the Medicaid teams to review available services and settings. These meetings help ensure a shared understanding of any changes over time, such as the introduction of new services or the development of new residential options. Through this coordination, the RCL team assesses whether new or modified settings meet the criteria for an MFP qualified residence. Based on those determinations, appropriate actions are taken to ensure the CARE electronic assessment tool is

configured to MFP eligible settings. The CARE electronic assessment tool documents the type of residence for each participant. All RCL participants are entered into the CARE tool. The CARE tool interfaces with the MMIS system and has been configured to ensure MFP services are only authorized in MFP qualified settings. This built-in logic links eligible setting types to appropriate funding codes so services cannot be authorized in unqualified settings. As a result, case managers document where the participant resides and authorizes services and this system logic ensures compliance with MFP requirements. Case Managers will have an information screen which alerts them to all RCL eligibility requirements including qualified institutional settings as well as qualified community residences.

The Washington State Administrative Code defines housing that is owned or rented by an individual as the present or intended place of residence:

1. In a building that you rent, and the rental is not contingent upon the purchase of personal care services;
2. In a building that you own;
3. In a relative's established residence; or
4. In the home of another where rent is not charged and residence is not contingent upon the purchase of personal care services.

In Washington State, an Adult Family Home is a residential home in which a person or persons provide personal care to more than one but not more than six adults who are not related by blood or marriage to the person or persons providing the services. Adult Family Homes are licensed for a specific number of beds and inspected by the Residential Care Services. A contract with DSHS – HCLA is necessary to provide services (and receive payment) to Medicaid consumers. MFP Participants transition into newly licensed homes or to homes who are supporting 1-4 unrelated individuals at the time of transition.

In the Washington Administrative Code, the category of Assisted Living includes Assisted Living, Enhanced Adult Residential Care, and Residential Care. It refers to any home or other institution providing housing, basic services, and assuming general responsibility for the safety and well-being of the residents. Assisted Living Facilities are licensed and inspected by the Residential Care Services division of HCLA. A contract with DSHS – HCLA is necessary to provide services (and receive payment) to Medicaid consumers. Some Assisted Living Facilities provide specialized dementia care.

DDA Specific HCBS Settings:

Supported Living: Supported Living is a service that supports clients to live in their home in the community with supports from a contracted agency. Individuals typically live with two or three housemates and staff provide teaching or support based on needs.

State Operated Living Alternatives (SOLA): Provides habilitation and other supports for individuals 18 and older in a home with up to four individuals. Housemates share living expenses while receiving shared staff support.

F.4. Other information

If needed, provide other information regarding the state or territory's transition coordination and housing processes and services that is not addressed elsewhere in the template.

Not applicable.

SECTION G. SELF-DIRECTION AND INFORMAL CAREGIVING

G.1. Self-direction

Describe any opportunities for MFP participants to receive HCBS as self-directed services.

The emphasis on person-centered planning in RCL will support more widespread use of self-direction and consumer empowerment – both essential elements for continued rebalancing of the long-term care system. Self-directed care in Washington is a model that supports and allows individuals with disabilities or older adults to have more control and freedom over their own care. This approach empowers participants to make their own choices regarding the services they receive, including who provides the care and how it is delivered.

Self-Direction has long been recognized as an important tool to promote independence and community care. It is governed through the broad authority of RCW 74.39.050 which states:

Individuals with functional disabilities -- Self-directed care.
(1) An adult person with a functional disability living in his or her own home may direct and supervise a paid personal aide in the performance of a health care task.
(2) The following requirements shall guide the provision of self-directed care under chapter 336, Laws of 1999:
(a) Health care tasks are those medical, nursing, or home health services that enable the person to maintain independence, personal hygiene, and safety in his or her own home, and that are services that a person without a functional disability would customarily and personally perform without the assistance of a licensed health care provider.
(b) The individual who chooses to self-direct a health care task is responsible for initiating self-direction by informing the health care professional who has ordered the treatment which involves that task of the individual's intent to perform that task through self-direction.
(c) When State funds are used to pay for self-directed tasks, a description of those tasks will be included in the client's comprehensive assessment, and subject to review with each annual reassessment.
(d) When a licensed health care provider orders treatment involving a health care task to be performed through self-directed care, the responsibility to ascertain that the patient understands the treatment and will be able to follow through on the self-directed care task is the same as it would be for a patient who performs the health care task for himself or herself, and the licensed health care provider incurs no additional liability when ordering a health care task which is to be performed through self-directed care.
(e) The role of the personal aide in self-directed care is limited to performing the physical aspect of health care tasks under the direction of the person for whom the tasks are being done. This shall not affect the ability of a personal aide to provide other home care services, such as personal care or homemaker services, which enable the client to remain at home.
(f) The responsibility to initiate self-directed health care tasks, to possess the necessary knowledge and training for those tasks, and to exercise judgment regarding the manner of their performance rests and remains with the person who has chosen to self-direct those tasks, including the decision to employ and dismiss a personal aide.

G.1.1. Termination of self-direction

Describe how the state or territory accommodates a participant who voluntarily terminates self-direction to receive services through an alternate service delivery method, including how the state or territory assures continuity of services and participant health and welfare during the transition from self-direction to the alternative service delivery method. Describe the circumstances under which the state or territory will involuntarily terminate the use of self-direction and thus require the participant to receive provider-

managed services instead. Specify procedures for switches from self-direction to provider-managed or other service delivery systems.

Voluntary Termination of Participant Direction:

An MFP participant can voluntarily terminate their participation in self-directed care without needing to disenroll from the demonstration. Participants can choose to revert to traditional agency-managed services at any time.

Involuntary Termination of Participant Direction:

The State does not have a mechanism for involuntary termination of participant direction. The State may terminate payment to an individual provider or agency for cause. In this case the Case Manager assures continuity of care.

By statute, DSHS can deny a client's choice of provider when the health, safety, and welfare of the client are in jeopardy. HCS has also established a "challenging cases" protocol, which gives us a mechanism for bringing the care team together to resolve issues of concern. This process can result in the termination of participant self-direction.

The challenging case protocol is used in less than 1% of WA's Medicaid caseload and occurs when all case management options/activities have been exhausted, and the client is still at risk due to poor decision-making capability, cognitive issues, and/or safety to self. In most instances the transition from self-directed to traditional service delivery occurs when a client has proven themselves not fully capable of hiring and supervising their own employee. In these cases, we discuss their choice of provider and suggest agency care instead of hiring an individual provider. This transition is usually made voluntarily with minimal disruption to services.

G.2. Other information

If needed, provide other information regarding self-direction and informal caregiving that is not addressed elsewhere in the template.

The Consumer Direct Care Network Washington exists to connect those who need in-home services with providers who are willing and eligible to work. Staff are available in-person, by telephone or e-mail, to help individuals learn more about becoming a provider or to assist individuals to find a qualified provider, substitute provider or access employer skills training.

- Family Caregiver Support is funded with State-only funding and Older Americans Act to provide respite, information and assistance, and training and support services to individuals who provide informal family care.
- DD Family Support is offered to families needing additional support to keep a child home.

SECTION H. REPORTING

H.1. Reporting plans and procedures

Describe how the state or territory will develop and implement a reporting plan and procedure for data collection, reporting, and participation in the MFP evaluation effort. The reporting plan must include data collection plans and procedures that demonstrate the state or territory's capacity to collect and share data for reporting the required program, expenditure, and financial information. States or territories must include a description of their T-MSIS data submission status and must address how identified T-MSIS data quality issues are being addressed.

Describe the reporting procedures for ensuring timely and complete data submissions to CMS, including quarterly, semi-annual, and annual reporting requirements; performance indicators and program outcome metrics; and continuous quality improvement and quality measures reporting.

Describe the strategies for ensuring that all partners and participants—including all affiliated departments, agencies, and providers—will participate in the project's evaluation.

Washington State has developed multiple reporting datasets for the collection and reporting of MFP data which pulls metrics and information directly from our CARE Assessment and documentation platform.

- RCL Discharge Report: Populates the number of individuals who discharged from RCL during a selected time period and shows how many times an individual has been enrolled and discharged on the program.
- RCL Enrollment Report: determines the number of people enrolled on MFP either pre-transition or within their demonstration period.
- RCL Disenrollment Report: used to track enrollment and disenrollment history and reasons for disenrollment for RCL participants.
- Discharge Tracking Report: this report tracks discharged clients for 12 full months by reviewing the length of time of the discharged individual receiving LTSS in a community setting. It incorporates claims data to identify institutionalizations and HCBS setting information.
- RCL No Discharge Report: This report identifies individuals enrolled in RCL who have been institutionalized for a period of greater than six months. MFP staff analyze these datasets monthly and amend estimated discharge dates as needed to address data quality issues and provides targeted outreach to case managers and help with transition planning, as needed.
- RCL RCS Citations: identifies MFP participants with a substantiated critical incident finding during their MFP enrollment while in a licensed LTSS setting.
- RCL APS Findings: identifies MFP participants with a substantiated critical incident finding during their MFP enrollment.
- RCL Setting at Discharge: identifies documented community setting type for MFP transitions during the specific reporting period.
- RCL Self Directed Care: determines how many clients self-direct their own care at any time during reporting period.
- RCL Reinstitutionalization: Provides a count of clients that were reinstitutionalized during the selected time period, including how many days they were in the institution and if the client returned to the community following institutional stay days.

- T-MSIS Verification Report: This dataset is used to address issues with T-MSIS data quality. This report provides MFP staff with a list of clients who should have been disenrolled from RCL as well as have no active RAC assigned in the RCL program. This report is generated prior to the submission of the TMSIS report that goes to CMS. This T-MSIS Verification Report data is analyzed monthly, and data fields are updated as needed to address data quality issues. In addition to data review and corrections, MFP staff conduct ongoing trainings and outreach to data entry personnel to improve reporting accuracy as it relates to MFP and T-MSIS.
- Acute Care Hospital Long Length of Stay: This report identifies referrals to Home and Community Services where the hospital resident has been admitted for over 30 days.
- State Hospital Discharge Tracking Report: The report identifies clients transitioning from state hospital or local psychiatric hospitals back to the community.
- Reporting systems that populate MFP identified service codes within the MMIS system
- Minimum Data Set (MDS) Acuity: A report which displays the most recent MDS coding for Medicaid residents in nursing facilities. This report is used to identify individuals with low acuity for targeted outreach for transition planning and MFP enrollment. This report is pulled ad hoc by NFCMs with a Data Use Agreement but is reviewed at a statewide level by MFP HQ staff monthly.

The state adheres to the data submissions to CMS by assigning responsible MFP personnel to oversee data collection, validation, entry and submission. MFP staff will perform pre-submission reviews to detect errors or discrepancies within the reports. If data quality issues are identified, the state will investigate discrepancies and correct errors before submission, provide additional staff training on data entry and/or enhance data collection systems to improve tracking.

To ensure timely and accurate data reporting, MFP staff meet routinely to discuss upcoming deadlines, progress updates and any challenges related to CMS reporting submissions. Additionally, staff will collaborate on strategies to improve data quality, ensure compliance with reporting requirements and streamline submission processes. By maintaining regular communication and coordination, the MFP team will enhance efficiency, minimize reporting errors and ensure that all quarterly, semi-annual and annual reports are submitted timely. In addition, CMS data submissions are verified by the state's MFP Project Director before submission, ensuring accuracy and compliance with data submission guidelines.

To support data quality in TMSIS reporting, MFP staff conduct monthly analysis of participant records by using the TMSIS Verification Report, as referenced above. This report was developed specifically to identify potential data issues such as mismatching or missing fields that could impact the accuracy of submitted data. Identified discrepancies are reviewed and corrected in advance of each monthly TMSIS submission to CMS. In addition to these routine data reviews, MFP HQ staff provide ongoing training and outreach to front-line regional staff to promote consistency and reduce recurring errors. HCS and DDA collaborate with the state's Medicaid agency, Health Care Authority (HCA), to support a more transparent and accurate TMSIS reporting. This ongoing effort focuses on improving alignment across systems and entities involved in reporting and on gaining greater clarity around how MFP-related data is extracted and submitted. The goal of this collaboration is to strengthen data accuracy and ensure the correct information is reflected in TMSIS submissions. The TMSIS state specific MFP report provided by CMS quarterly is reviewed for anomalies or unexpected figures which may indicate potential data integrity issues within the MFP TMSIS reporting process.

SECTION I. QUALITY MEASUREMENT, ASSURANCE, AND MONITORING

I.1. Quality assurance and improvement

I.1.1. Quality management strategy

Provide as an appendix a comprehensive and integrated quality management strategy. Describe how the state or territory assures quality and continuously improves the quality of HCBS under the state or territory Medicaid program, and assures the health and welfare of individuals participating in the MFP Demonstration. In the Work Plan, include state or territory initiatives to improve the quality of services received by individuals receiving HCBS through the MFP Demonstration and the systems that serve them. Include how the state or territory monitors and evaluates the quality of services provided to MFP participants (including supplemental services), the roles and responsibilities of all agencies involved, and remediation and improvement processes.

Describe the program's targeted system performance requirements, including that (1) the state conducts level-of-care need determinations consistent with the need for institutionalization, (2) plans of care are responsive to participants' needs, (3) qualified providers serve participants, (4) health and welfare of participants is protected, (5) state or territory Medicaid agency retains administrative authority over the program, and (6) the state or territory provides financial accountability of the program.

If the state or territory plans to integrate the MFP program into a new or existing section 1915(c) HCBS waiver program, section 1915(i) state plan HCBS, section 1915(j) self-directed personal care services, section 1915(k) Community First Choice, or a section 1115 demonstration, provide a link to the approved quality improvement system (QIS), for example as found in:

- Appendix H of the section 1915(c) HCBS waiver application
- QIS information provided in the section 1915(i) state plan application
- The quality assurance and improvement plan used to monitor and evaluate the section 1915(j) self-directed option
- The quality assurance and improvement strategy used to monitor the section 1915(k) Community First Choice State Plan option
- Section IV of the section 1115 demonstration application, describing how delivery system reforms will impact quality, access, cost of care, and health status of the covered populations

Describe how the HCBS state plan, section 1115 demonstration, or waiver program's existing QIS is or will be modified to ensure adequate oversight and monitoring of the MFP program.

For purposes of quality management, the State integrates the MFP demonstration into existing 1915(c) and State plan quality management strategies as per the embedded Appendix H: Waiver WA. Please note that this document refers to the name of our Administration at the time of the approval: Aging and Long-Term Administration (ALTSA). Our Administration name changed in May 2025 and is now called the Home and Community Living Administration (HCLA).

Appendix H QIS for 1915(c).pdf

The State has an extensive, approved quality strategy for HCBS waivers and our State Plans, to include the HCLA operationalization of the Community First Choice 1915(k) plan. State plan personal care

monitoring and improvement is integrated into the approved strategy. RCL will have the same level of quality oversight as existing programs including all assurances and activities required in Appendix H of the 1915(c) HCBS waiver application. Washington's Quality Management Strategy covers all HCBS recipients including those served under the State Plans.

Following the demonstration year, we anticipate that most RCL participants will be served through one of the Department's 1915(c) waivers or 1915(k) State plan, and that the QMS will continue to address the required assurances. It is possible that State plan personal care could meet the needs of an individual recipient after the demonstration period.

ASSURANCE #1 – Level of Care Determinations

Washington uses the Comprehensive Assessment Reporting and Evaluation (CARE) tool to assess and reassess level of care. This is the sole tool used for determining levels of care. All applicants with a reasonable indication of future service needs receive a level of care determination. RCL participants receive an initial CARE assessment and are reevaluated annually or after significant changes. Evaluation timeliness is monitored through established Quality Management System processes.

Washington monitors level of care decisions and addresses inappropriate determinations. Home and Community Services supervisory staff review reports and take corrective action taken continuously. Case managers must act within set timeframes to resolve issues identified through supervision and quality assurance monitoring. CARE Management Reports track key data, including dates of intake, assignment, and assessment, assigned Case Manager, assessment status (make payment), setting, and transfer dates. Quality Assurance Proficiency and Follow-up Reports document level of care decisions and corrective actions, ensuring timely assessments and eligibility determinations. Quality Assurance roll up reports are reviewed at all system levels. Case managers receive individualized proficiency reports, supervisors get unit reports, Regional Administrators and Area Agency on Aging Directors receive regional reports, and HCLA Headquarters reviews aggregate data.

ASSURANCE #2 – Person-Centered Plan of Care

Washington's system ensures that plans of care are responsive to participant's needs through a structured system of assessment, monitoring and quality management. Case managers collaborate with clients to develop person-centered care plans that address needs, risks, goals, and preferences. Plans are reviewed regularly, including during office transfers or as needs change, and updated annually or sooner if necessary.

Monitoring ensures services match the specified amount, duration, and frequency while meeting individual needs. The CARE tool allows case managers to document safety concerns, including emergency response system, evacuation in an emergency, necessary environmental modifications, consumer training needs, health risks, durable medical equipment, cognitive deficits, caregiver supervision, any recent history of falls, substance use, signs of depression, caregiver burnout, suicide risk, and other high-risk indicators. Case managers review person-centered care plans with providers before implementation and must act within set timeframes to address inadequacies. These measures, along with Quality Management processes, ensure that plans remain effective and responsive to participant's evolving needs.

The following elements are documented in Quality Assurance Application and CARE Reports:

- Needs identified in the level of care are adequately addressed in the participants' Plan of Care
- The Plan of Care is consumer directed and plans are completed in required time frame
- Participants receive the services identified in the plan of care
- Participants are provided with a free choice of providers
- Plans are reviewed and revised in response to participant direction or change in needs

Quality Assurance Monitoring Process Overview:

1. A statistically valid sample is pulled statewide per program;
2. The area sample is pulled based on the percentage of population for each program in each geographical area;
3. The calendar is developed and distributed;
4. QA unit provides training;
5. QA Notices are emailed to each area prior to the start of the review cycle;
6. Monitoring occurs; three-day issues are addressed; and
7. An Exit Conference is optional and conducted virtually at the completion of the review.
8. Areas have 30 calendar days to make required corrections and QA document remediation.

Local case management supervisors/managers complete a review of four records per worker per year, and case managers provide ongoing review of the client's service plan and services provided several times throughout the year. In DDA, a statistically valid audit of files is done yearly as well as a monthly supervisory review of files. DDA Quality Review Managers also review files at least yearly as well as on an ongoing basis as needed.

ASSURANCE #3 – Qualified Providers

Washington ensures that qualified providers serve participants through rigorous contracting and monitoring processes. The Quality Management System requires verification of licensing, certification or any other qualifications before contract execution, with payments restricted to valid contracts.

A statistically valid sample of provider files is regularly reviewed to confirm ongoing compliance. The provider contract monitoring system, as outlined in the approved Quality Management System, includes periodic reassessments to ensure providers continue meeting qualifications. Licensing and certification are re-verified at contract renewal and per individual schedules. For providers without required licensing, the state monitors qualifications based on approved waivers and the state plan. Existing systems will be used for RCL service providers. If a provider fails to meet qualifications, corrective action is taken, including potential contract termination if compliance cannot be achieved.

DSHS contracts with Area Agencies on Aging to perform certain waiver functions. Copies of these contracts are on file at the Medicaid agency. On-site contract monitoring of Area Agencies on Aging is performed on a two-year rotation schedule, and more frequently at the discretion of the State. Performance is measured as per the terms of the contract, the waiver and identified delegated functions.

Individuals in RCL (and in existing programs) can choose to self-direct their personal care. This means they hire, fire, train and supervise their own providers. Consumer Direct Care Network Washington (CDWA) is the contracted Consumer Directed Employer (CDE). To support adequate protections for consumers the CDWA oversees regulation, background checks, contracting and continuing education of individual providers. Specific and extensive requirements are noted in Washington Administrative Code (WAC 388-71). CDWA monitors individual provider files to ensure that these requirements are met. Providers who fail to meet requirements are not offered a contract or, for existing providers, the contract is terminated.

The Quality Management System specifies response times for addressing provider qualifications and conduct issues. Immediate action is required for payment errors, consumer safety risks, rights violations,

abuse, neglect, exploitation, and poor care without documented intervention. Policy also defines timelines for resolving provider contracting and training issues to ensure compliance and service quality.

ASSURANCE #4 – Health & Welfare

HCLA and DDA have strong systems to protect vulnerable adults in home and community settings. The Quality Management Strategy includes scheduled face-to-face visits, abuse/neglect prevention training, community education, increased monitoring when risks are identified, and mandatory referrals to protective services (adult protective services, residential care services, child protective services) and law enforcement for allegations of abuse, neglect, abandonment, or exploitation.

Protective service activities are tracked through standard and customizable reports through the Adult Protective Services automated system. Access follows a three-level hierarchy: individual workers view their cases, supervisors and program managers access regional data, and upper management accesses individual worker, regional, and statewide reports. These reports support ongoing evaluation, trend analysis, and workload management. As noted above in the plan of care assurance, safety concerns are documented and addressed in the participant's person-centered plan of care.

ASSURANCE #5 – Administrative Authority

Multiple divisions have operational roles with WA's MFP program within the Home and Community Living Administration. Home and Community Living Administration has a cooperative agreement with the Health Care Authority (HCA) to administer and operate long-term services and supports. HCA is the Medicaid Agency and employs the State Medicaid Director (SMD).

The MFP Demonstration is operated by The Developmental Disability Administration (DDA) for those MFP participants exiting I/DD institutional settings. DDA provides HCBS to this I/DD target population, and Home and Community Services (HCS) provides HCBS to older adults, disabled adults and adults with Mental illness as part of the Department of Social and Health Services. An organizational chart of the administrative structure can be found in Section B.

ASSURANCE #6 – Financial Accountability

State financial oversight assures that claims are coded and paid in accordance with the reimbursement methodology specified in approved programs. The same methodology will be used for RCL. HCLA and DDA are meeting this assurance through established Quality Improvement strategy that embeds monitoring of financial accountability and integrity. Monitoring is performed by HCLA Headquarter managers responsible for ensuring compliance with financial management policy and procedures.

Quality assurance monitoring related to financial integrity occurs at local, regional and statewide level using a variety of financial data and reports and includes analyzing aggregate data to discover statewide and/or regional trends. Financial irregularities or errors/adjustments made by the State and/or providers are identified, addressed, and corrected.

Financial records are maintained by the State, regional managing entities, and providers, as specified. CARE payments are entered through electronic interface, and a history of payment is maintained in ProviderOne. Errors are corrected when identified within the initial monitoring review and follow up review occurs to ensure that corrections are complete.

The Quality Assurance Unit develops initial, 30-day, and follow-up and approves any corrective action plans. Social Services Supervisors are responsible for reviewing four records per case manager per year in addition to all records being transferred between offices. Supervisors/local managers can perform targeted or additional reviews if concerns arise.

The Payment Systems Unit runs algorithms to identify errors in service authorization and ensure that duplicate payments are not occurring. Continuous automated data systems that track waiver status and provider payments are utilized. These reports may identify overpayments and result in recovery actions.

In addition to embedded Quality Assurance activities that monitor financial functions, HCLA also audits yearly a random sample of waiver consumer plans of care for financial integrity. The ProviderOne Payment System used to pay providers is continuously monitored for promptness and accuracy utilizing live data. An HCLA Headquarters committee reviews and decides when an exceptional rate is requested to ensure compliance.

Program Managers review payment data for their programs, address as appropriate, and follow-up to ensure payment corrections are made. WA maintains documentation showing the results of its financial monitoring process.

Supplemental demonstration services

Monitoring RCL services will be integrated into the existing Quality Management System. Washington will use the same monitoring process for evaluating the adequacy of services including demonstration and supplemental services. The approved system includes remediation and improvement processes. Additional monitoring will evaluate whether transition plans meet Quality Assurance standards.

I.1.2. Quality assurance attestation

☒ Select this box to indicate the state or territory will cooperate in carrying out activities to develop and implement continuous quality assurance and quality improvement systems for HCBS and LTSS.

I.1.3. HCBS quality measures

Describe how your state or territory plans to select an experience of care survey or surveys for each of the major population groups included in the state or territory's HCBS program from the HCBS Quality Measures and report on the survey data.

Washington State contracts with the University of Washington (UW) to complete experience of care surveys through the NCI-AD tool for HCS and the NCI-ID tool for DDA. Currently, HCS is administering the NCI-AD survey annually while DDA plans to administer the NCI-ID survey on alternating years and both include MFP participants. HCLA Quality Assurance Program Manager provides initial sample information to ensure a representative sample is provided to include smaller populations of people. UW conducts the survey and compiles data. The HCLA QA Program Manager monitors progress toward survey completion. The current NCI-AD reports are posted on the NCI-AD website.

Describe any limitations in the data sources, sampling strategy, or calculations used to report the HCBS Quality Measure Set, as well as any other anticipated challenges for reporting.

The NCI-AD, itself, is only available in English and Spanish currently. UW contracts with interpreter services to translate any other languages encountered in the sample. The survey protocol also allows family members to interpret, if available. At ALTA's request, UW attempts to hire surveyors who speak additional languages but it's not always possible. Survey fatigue is a potential factor with clients in the future, especially for the smaller demographic populations.

HCLA and DDA continue to explore the report logic and data shared through TMSIS. Because there are several entities involved in the process of exporting and reconciling the data, there have been challenges in verifying all data shared.

Describe how HCBS Quality Measure Set data will be used to support MFP program monitoring and improvement.

HCBS Quality Measure set data will help to inform the quality of HCBS delivery and be used to improve health outcomes, quality of life, and community integration for individuals relying on long term services and supports.

Please list the responsible party and any key partners for reporting on the HCBS Quality Measure Set and driving improvement.

Home and Community Services and Developmental Disabilities Administration are responsible for reporting on the HCBS Quality Measure Set and driving improvement. Key partners include Health Care Authority for components of data, and the University of Washington is conducting experience of care survey activities which are overseen and directed by HCLA: HCS and DDA. Results are also shared with Health Care Authority (HCA).

I.2. Additional MFP quality assurance requirements

Describe how the state or territory will address the three additional MFP quality assurance requirements for (1) 24-hour backup systems for crucial services, (2) risk assessment and mitigation, and (3) incident management. For each requirement, describe how the state or territory will monitor its use and effectiveness and explain any variations by target population, geography, or any other factor. Describe the protocol for the reporting of incidents to the state or territory's critical incident systems for the state or territory's HCBS program(s).

I.2.1. 24-hour backup systems for critical services

Using the table shell below, describe any 24-hour backup systems accessible by Demonstration participants, as well as how participants can access the systems (for example, toll-free telephone number or website). The state or territory should describe, at a minimum, the backup systems related to (1) critical services, (2) transportation, (3) direct care workers, (4) repair and replacement for durable medical equipment (DME) and other equipment (including provision of loaning equipment while repairs are being made), and (5) access to medical care (including how participants are assisted with initial appointments, how to make appointments, and how to deal with appointment or care issues). Add as many rows as needed to capture all backup systems available to Demonstration participants.

Table I.2.1. 24-hour backup systems

Backup system	Description of system	Participant access
Critical services	911: Can be used when an emergency is occurring. Average statewide response time is 7 minutes. Records are kept of all these calls.	911 emergency services are available via telephone.
Critical Services	988: statewide crisis hotline. All RCL participants will have access to this 24-hour support regardless of diagnosis.	Crisis hotline 988 is available via toll-free telephone. It is available through the Health Care Authority and BH-ASO which operate all behavioral health services.
Critical Services	Adult Abuse 1-866-363-4276 line & online referral portal can be accessed to report abuse for participants.	Adult Abuse reporting can be accessed via toll free telephone 1-866-ENDHARM as well as DSHS Report Abuse website

Backup system	Description of system	Participant access
Critical Services	Department of Health- Emergency Medical Services, Washington's systems comprehensive approach to trauma and cardiac and stroke events provides: • Injury and illness prevention • Emergency medical services (EMS) care • Hospital emergency department care that includes resuscitation, stabilization and transfer when needed • Hospital inpatient care • Rehabilitation services • System monitoring and evaluation	Department of Health allows MFP recipients to access the following websites: • DOH Local Health Jurisdictions • DOH Emergency Medical Services
Critical Services	Personal Emergency Response System (PERS) unit is an electronic system whereby an individual can secure help in an emergency through an electronic device that is connected to the individual's phone and programmed to signal a response center, staffed by trained professionals who will immediately summon help for the client. PERS units can feature Assistive Technology (AT) for fall detection and/or medication management based on recipient's needs and care plan.	The case manager ensures that the participants have access to the assistance and support for the PERS unit that will be available under the demonstration. When the client receives the device support contact information is also given by the contracted provider.
Transportation	Medical transport: Health Care Authority (HCA) covers non-emergency transportation for eligible clients to and from covered health care services through transportation brokers. The brokers schedule the transportation for qualifying clients. Currently, Medicaid eligible clients to include RCL and other waiver and state plan programs include a medical transportation benefit.	Medical transport brokerage can be accessed via phone or fax specific to each county for all RCL participants. Participants can find local brokerage on Health Care Authority's website : Health Care Authority Medical Transportation Brokerage List

Backup system	Description of system	Participant access
Transportation	Personal Care providers can transport clients based on plan of care.	Clients can contact their in-home provider for transportation with a caregiver. CDWA Toll Free line 866-214-9899 Website for Consumer Direct Care of Washington (CDWA) for clients that need assistance obtaining an in-home provider.
Transportation	A statewide non-medical transportation provider, Medstar Transportation, is available for all RCL participants.	Clients can call their case manager for assistance with the immediate transportation needs. Transportation may be approved for individuals that do not have transportation for health care appointments.
Transportation	Community Choice Guides, a contracted provider, may be available to provide transportation.	Clients can call their case manager for assistance with the immediate transportation needs.
Direct care workers	Individual Provider back up: the Consumer Direct Care Network Washington (CDWA) is a resource available to help identify local caregiver back up as part of the plan of care. These resources are documented in the plan of care.	There is a 24-hour statewide hotline and online portal to access this service.
Direct care workers	Provider Agency back up: Agency back-up may be required for some RCL participants if indicated in the assessment. Agencies are required to have a means by which clients can contact them during the hours of care provided by that Agency. This is always noted in the plan of care. If an agency needs to be assigned for back-up purposes for health and safety reasons, the particular agency is decided by factors of availability, geography, and client choice.	Provider Agency contact information is given to recipient during initial meeting to set up services from provider for caregiving services.

Backup system	Description of system	Participant access
Direct care workers	Smart Care Companion service is a remote support service device that interacts and engages with a client to provide support through proactive suggestions, cuing and reminders for ADL &/or IADL tasks or health-related activities, and accessing their community. The device provides the following features: • Case management dashboard • Video calling via assistive • technology. • Live audio feed; and • Web-based systems. • Interactive Artificial Intelligence (AI) system-voice commands and proactive suggestions • Health and Wellness feature applications • Digital and audio messaging	RCL participants in home settings are able access this service based on plan of care. They can contact their case managers with issues as well as access the website for Intuition Robotics-ElliQ or email the Helpdesk: help@elliq.com. Telephone Support is available toll free: 855-888-1295
Repair and replacement for DME and other equipment	Clients that have need for repair and replacement for Durable Medical Equipment and other equipment can call their case manager for assistance with the immediate problem. Community Choice Guides may be available to assist with problem solving during the initial intensive transition process. Managed Medicaid Plans: Each managed care plan also provides Value-Added Benefits for their members. These are benefits that are not part of the standard Medicaid benefit package and are administered by the MCO not HCA. DME benefits vary based on the client's health plan.	All RCL participants have an assigned case manager they can contact via telephone or email to request assistance for repair and replacement for DME and equipment. Clients assigned to Managed Care plans can contact the provider to assist with DME via toll free telephone or websites listed below. Community Health Plan of Washington 1-800-440-1561 Coordinated Care 1877-644-4613 Molina Healthcare of Washington 1-800-869-7165 United Healthcare Community Plan 1-877-542-8997 Wellpoint Washington 1-833-731-2167

Backup system	Description of system	Participant access
Access to Medical care	Health Home (HH) services are a set of optional Medicaid benefits available to eligible clients. Participation is voluntary, at no cost to clients, and does not change or duplicate services currently being delivered. A Care Coordinator (CC) steps in when a service is needed and is not already being provided, to bridge gaps in care. The HH program is designed to ensure cross systems coordination and care transition; Increase confidence and skills for self-management of health goals; and create a single point of contact responsible for bridging all systems of care.	HealthHomes@HCA.WA.GOV Health home leads contact
Access to Medical Care	Find a Provider Search tool: A directory of providers who have registered as accepting new Apple Health clients.	HCA Find-a-Provider

Backup system	Description of system	Participant access
Access to Medical Care	Apple Health Medicare Connect: Eligibility and enrollment with Dual Eligible Special Needs Plans (D-SNP). All plans have care coordinators who can assist with accessing benefits. Need help understanding your Apple Health Coverage? video tutorial. What Apple Health benefits and Services are covered?	**Community Health Plan of Washington** Current members: 1-800-942-0247 Prospective members: 1-800-944-1247 **Coordinated Care (WellCare)** Current members: 1-833-444-9089 Prospective members: 1-866-527-0056 **Humana** 1-800-457-4708 **Molina Healthcare of Washington** 1-866-403-8293 **UnitedHealthcare Community Plan of Washington** Current members: 1-866-944-4984 Prospective members: 1-888-834-3721 **Wellpoint Washington (previously Amerigroup)** 1-844-812-2275 https://youtu.be/gxrmov_66Uc https://youtu.be/smvb64n7UiE
Access to Medical Care	Contacted Providers: Community Choice Guides and/or Client Training providers, can assist with setting up initial appointments and meeting with new providers, and support skill building with identifying and scheduling appointments with providers and support problem solving of appointment or care issues	Provider Contact information is included in the Person-Centered Care Plan
Access to Medical Care	Agency or individual caregivers can assist with scheduling, rescheduling and support problem solving of appointment issues	Caregiver or Agency Caregiver contact information is provided in the Person-Centered Care Plan.
Other (describe):		

Describe the organization of 24-hour backup systems. Explain which state, territory, or local agencies are responsible for providing 24-hour, seven day per week emergency backup in all geographical areas in which the MFP Demonstration will operate and for each target group if it varies.

For Home and Community Based Services, back-up plans are individualized. Each participant will have a case manager assigned prior to transition and while receiving home and community-based services. Person-centered care plans are not considered complete until an individualized back-up plan is in place.

Back-up plans can include the use of a home care agency which can provide back-up support when needed, several Individual Providers who back each other up, and the use of informal supports that can be called in when needed. Individual Providers can also be obtained through Consumer Direct Care Network Washington (CDWA) available statewide. Consumers who have difficulty with transportation or with repair and replacement of their Durable Medical Equipment can call their case manager for assistance with the immediate problem. Contracted providers, like Community Choice Guides, may be authorized to assist with problem solving during the initial intensive transition process, or as needed to maintain community living.

Back-up plans are discussed, planned for, and documented during the assessment process. This multi-tiered approach includes individualized supports, additional agency or contracted back up as needed, and statewide emergency response systems to include:

- Informal supports as identified by participant and team: Emergency contacts are documented in the CARE plan.
- Personal Emergency Response System (PERS) is an electronic system whereby an individual can secure help in an emergency through an electronic device that is connected to the individual's phone and programmed to signal a response center, staffed by trained professionals who will immediately summon help for the client.
- Individual Provider back up: the Consumer Direct Care Network Washington (CDWA) is a resource available to help identify local caregiver back up as part of the plan of care. These resources are documented in the plan of care. There is a 24-hour statewide hotline and online portal to access this service.
- Provider Agency back up: Agency back-up may be required for some RCL participants if indicated in the assessment. Agencies are required to have a means by which clients can contact them during the hours of care provided by that Agency. This is always noted in the plan of care. If an agency needs to be assigned for back-up purposes for health and safety reasons, the specific agency is decided by factors of availability, geography, and client choice.
- Case Managers: Every consumer has a case manager assigned to them for the duration they receive home and community-based services. Detailed notes are kept of case management activities which include monitoring all contacts.
- RCL contracted resources: Contracted individuals and agencies will be asked about their ability to provide 24-hour backup in cases where there is limited or no informal support. This will be documented in the plan of care.
- 988: statewide crisis hotline. All RCL participants will have access to this 24-hour support regardless of diagnosis. It is available through a collaborative effort between the Department of Health and Health Care Authority.

- Native and Strong Lifeline – 988, Press 4: a crisis hotline for every Native person seeking support. The crisis hotline is staffed by all-Native counseling staff.
- Adult Abuse 800 line & online referral portal: This is another resource available to all RCL participants and their care teams.
- 911: Calling this number offers public medical and safety emergency response service available statewide. The 911 Unit of the Emergency Management Division oversees the statewide 911 communications system, ensuring efficient access to public safety services. Additionally, the Seattle CARE Department operates the 9-1-1 Communications Center in Seattle. The 911 Unit of Emergency Management Division works to ensure the seamless operation of the statewide 911 communications system. Ensuring uniform, prompt and efficient access to public safety services for the citizens and visitors to the state of Washington. Washington has 78 Public Safety Answering Points (911 centers) that cover all 39 counties within the State. Each Primary Public Safety Answering Point (PSAP) is connected to the statewide network, which delivers location information of the 911 caller as well as other data needed.

Describe the process for receiving and resolving participant complaints when the backup systems and supports do not work.

The process for receiving and resolving participant complaints when backup systems and supports do not work is rooted in the principle of person-centered planning and the acknowledgment of the "dignity of risk." Washington State is committed to ensuring Roads to Community Living (RCL) participants have robust crisis and backup plans to minimize disruptions, but it also recognizes that living in the community inherently carries some level of risk.

Complaint Resolution Process

1. **Evacuation Plans and Risk Discussions**: Every participant's care plan must include an evacuation plan as per Long-Term Care Manual, Chapter 3. Per Person-Centered Planning and Service Delivery guidelines:
    - If evacuation without assistance is difficult or impossible, the case manager engages the participant in a discussion about the risks involved and potential outcomes.
    - The case manager also provides information about alternative long-term care settings that may better meet the participant's needs while reducing risk.
    - If the participant decides to remain at home despite the risks, their decision is documented as part of their person-centered plan.
2. **Crisis and Backup Plan Failures**: If backup systems and supports fail, the following steps are taken:
    - **Receiving Complaints**: Participants or their representatives can report issues through designated channels, such as hotlines, case managers, or online complaint forms.
    - **Complaint Resolution**: Case managers and other designated personnel review complaints and work collaboratively with participants to address their concerns. This includes revising care plans, enhancing backup supports, or facilitating transitions to alternative settings if necessary.
3. **Dignity of Risk and Participant Empowerment**: The state emphasizes the importance of honoring participant autonomy. While steps are taken to mitigate risks, participants retain the right

to make informed decisions about their care and living arrangements. Complaints are addressed with the understanding that community living entails a balance between safety and the dignity of personal choice.

4. **Ongoing Communication and Follow-Up**: The state ensures participants are kept informed throughout the resolution process and conducts follow-ups to verify that their concerns have been adequately addressed.

This framework not only addresses immediate issues but also strengthens the overall system to better support participants in their community living goals.

I.2.2. Risk assessment and mitigation

Describe the organization of risk assessment and mitigation processes for all program participants, including monitoring.

The risk assessment and mitigation process include several key components to ensure participants' safety and well-being.

Risk Assessment and Monitoring Process:

- Risk Assessment for Providers: To receive a contract to serve DSHS clients, risk assessments are conducted for all new contracted providers to ensure provider integrity, compliance with public policy, record of past performance as well as financial and technical resources. Providers must meet the following minimum qualifications:
    - At least one year of demonstrated experience and ability to provide services per the specifications of the contract unless more experience is required in the specific provider qualifications listed below.
    - Current Washington State Business License or an explanation of why you are exempt from registering your business with the state of Washington.
    - Demonstrated capacity to ensure adequate administrative and accounting procedures and controls necessary to safeguard all funds and meet program expenses in advance of reimbursement, determined through evaluation of the agency's most recent audit report or financial review. A waiver of this requirement may be available for businesses that have been in operation for less than one year or for self-employed contractors who will only provide a direct service with no employees and no fiduciary responsibility.
    - Owners, managing employees, and anyone with a controlling interest (board of directors) of the agency have not been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or Title XVII, XIX, or XX, nor have they been placed on a Federal exclusion list or otherwise suspended or debarred from participation in these programs.
    - Insurance requirements listed in the DSHS contract. Local areas may require higher minimum coverage. Subcontractors, or any agency that is paid to carry out any of the duties of the contract, must maintain insurance with the same types and limits of coverage as required under the contract.
    - The agency owner/contract signatory must pass a DSHS criminal history background check. All employees, volunteers, and subcontractors who may have unsupervised contact with vulnerable adults must have passed a criminal history background

check, which must be conducted by the contractor every two years and kept in personnel or subcontractor files. The criminal history background check must at least include Washington State Patrol criminal conviction records.

- No history of significant deficiencies as evidenced by monitoring, licensing reports or surveys, including Area Agency on Aging monitoring reports, if applicable.
- Have sufficient staff qualified to provide services per the DSHS contract terms as evidenced by a current organizational chart or staffing plan indicating position titles and credentials, as applicable. This also includes any outside agency, person, or organization that will do any part of the work defined in the DSHS contract.
- Have no cases of lost litigation related to service provision to medically frail and/or functionally disabled persons.
- Provide services throughout the defined service area. The service area is defined by the contracting Area Agency on Aging.

- Contract Monitoring and oversight: HCLA and Area Agencies on Aging (AAA) conduct risk assessments as part of their procurement and contract monitoring activities of contracted providers. This monitoring process includes quality improvement initiatives and contract management to mitigate risks to ensure providers meet quality and compliance standards.
- Single Audit Act Compliance. If the contracted provider is a subrecipient and expends $750,000 or more in federal award from any and/or all sources in any fiscal year, the contractor shall procure and pay for a single audit or a program-specific audit for that fiscal year.

Safety and Protection Measures:

- Adult Protective Services (APS) & Residential Care Services (RCS) monitor and address risks related to abuse, abandonment, neglect, and financial exploitation of vulnerable adults, including MFP participants.
- Background Check: Those who have unsupervised access to clients while performing their work are required to complete a criminal history background check prior to any unsupervised access to DSHS clients.
- Medicaid Fraud Department is responsible for both criminal and civil investigation and prosecution of healthcare provider fraud committed against the State's Medicaid program. The division also investigates and prosecutes complaints of resident abuse or neglect in nursing homes, adult family homes and assisted living.

These combined efforts help safeguard program participants while maintaining high-quality care and services.

I.2.3. Incident management system

Assure that MFP critical incidents are reported through the state or territory's incident management systems for Medicaid HCBS. Describe the organization of the incident management system used to monitor the health and welfare of MFP participants. Identify the state or territory entity responsible for receiving, reviewing, and responding to MFP critical incident reports and investigating consumer complaints regarding violation of their rights. If applicable, clearly describe how the policy differs by situation (for instance, by participant population group, qualified institutional setting, or operating division).

The state's incident management system is structured to monitor the health and welfare of all vulnerable adults regardless of MFP participation status, by ensuring that all critical incidents, including abuse, abandonment, neglect, and financial exploitation of vulnerable adults are appropriately reported, reviewed and investigated.

Adult Protective Services (APS) is the state entity responsible for receiving, reviewing and responding to critical incident reports and investigating complaints related to abuse, abandonment, neglect, and financial exploitation of vulnerable adults.

If the client is residing in a licensed long-term care facility such as a nursing home, adult family home, assisted living, adult residential care, enhanced adult residential care, enhanced service facility, intermediate care for individuals with intellectual disabilities, or receiving certified supported living services, Residential Care Services, Complaint Resolution Unit (CRU), is the designated entity responsible for receiving, reviewing and investigating complaints regarding potential violations of participant rights and quality of care within these settings.

Mandatory Reporters and referents are encouraged to make a report online through DSHS online report portal. The benefits of online reporting include a confirmation number and 24-hour, seven days a week availability. Alternatively, reports can also be made by phone.

All DSHS employees, owners or employees of a nursing home, Assisted Living Facility, or adult family home and contracted individual providers for a DSHS client are Mandated Reporters and are required to report any concerns involving a client or any other vulnerable adult/child, regardless of their MFP participation status.

Mandatory reporters must also make a report to law enforcement if they suspect a vulnerable adult has been sexually or physically assaulted, or if they have reasonable cause to believe that an act has caused fear of imminent harm.

Case managers play a critical role in ensuring participant safety by assessing client safety, including potential abuse, neglect, suicidal ideation or environmental concerns during each comprehensive assessment. If any safety concerns arise, they must take immediate action by making the necessary referrals and reports to 911, APS or CRU.

Washington State employs strict protocols regarding the reporting of abuse, neglect, and exploitation. The following resources illustrate ways that participants, family members, caregivers and/or legal representatives are provided with information about protections from mistreatment and told how to report concerns or incidents of abuse, neglect, and exploitation:

- Comprehensive Assessment Reporting and Evaluations address potential abuse, neglect and exploitation;
- Participants review and sign a form entitled "Your Rights and Responsibilities" (including the right to be free from abuse…) at the time they accept services;
- The participant financial eligibility process includes a review of funds and information on consumer financial rights;
- Provider training (e.g., Caregiver Orientation, and Revised Fundamentals of Caregiving and Safety Training);
- DSHS internet websites;
- DSHS End Harm campaign and the activities associated with the annual statewide July Adult Abuse Prevention month;

- The Washington State Long-Term Care Ombudsman advocates for residents of nursing homes, adult family homes, and assisted living facilities. Their purpose is to protect and promote the Resident Rights guaranteed these residents under federal and state law and regulations.
- DDA consumers receive the Roadmap to Resolution brochure and can file a complaint through the DDA website;
- Behavioral health consumers receive information on the Office of Behavioral Health Advocacy (formerly known as Behavioral Health Ombuds).

In addition, the state has developed multiple reports to identify MFP participants with a substantiated critical incident finding during their MFP enrollment. These reports are used to report on critical incidents related to MFP participants to CMS as necessary.

I.3. Other information

If needed, provide other information regarding the state or territory's approach to quality that is not addressed elsewhere in the template.

Not applicable.

SECTION J. CONTINUITY OF CARE POST-DEMONSTRATION

In accordance with section 6071(c)(2) of the Deficit Reduction Act of 2005, the MFP Demonstration must operate in connection with a qualified HCBS program to assure continuity of services for eligible individuals.

Select this box.

☒ The state or territory affirms that it has established procedures and processes for ensuring that the provision of HCBS will continue for an MFP participant at the conclusion of the 365-day enrollment period for as long as an individual remains eligible for medical assistance.

SECTION K. EQUITY

Describe how your state or territory's MFP Demonstration assesses or measures equity concerns and considerations that relate to your state or territory's MFP Demonstration. These should relate to consistent and systematic fair, just, and impartial treatment of all individuals, including individuals who belong to underserved communities that historically have been denied such treatment, such as Black, Latino, Indigenous and Native American persons, Asian Americans, Pacific Islanders, and other persons of color; members of religious minorities; lesbian, gay, bisexual, transgender, and queer (LGBTQ+) persons; persons with disabilities; persons who live in rural areas; and persons otherwise adversely affected by persistent poverty or inequality.[2] As a reminder, please use the MFP Work Plan to describe any initiatives relevant to this section, including specific and measurable objectives, MFP and state or territory funding, and evaluation efforts.

K.1. Disparities in enrolling or participating in MFP

K.1.1. Assessing and measuring disparities in enrolling or participating in MFP

Describe how your state or territory's MFP Demonstration assesses or measures disparities in enrolling or participating in MFP, or your state or territory's plan to assess or measure these disparities. Include a description of the areas in which disparities are or will be measured, such as race/ethnicity, religion, geography, type of disability, gender identity, and sexual orientation.

Intentionally left blank.

K.1.2. Cultural competency

Describe how your state or territory's MFP Demonstration will assess the cultural competency of its provider network.

Intentionally left blank.

K.1.3. Data sources for measuring disparities

Describe the availability of data for measuring or assessing equity and disparities in enrolling or participating in your MFP Demonstration. Describe barriers to obtaining data on equity and disparities and how your MFP Demonstration plans to address or overcome these barriers.

Intentionally left blank.

K.2. Social determinants of health

K.2.1. Assessing and measuring social determinants of health

Describe how the state or territory's MFP Demonstration is or will be measuring or assessing whether it is promoting, providing, or facilitating access to the social determinants of health (SDOH) and other needed services. Include a description of the specific SDOH that are or will be measured, such as food insecurity, transportation, medical devices and supplies, education, and social and community supports.

Intentionally left blank.

[2] This definition of equity was established in the Executive Order on Advancing Racial Equity and Support for Underserved Communities Through the Federal Government. The Executive Order is available at https://www.whitehouse.gov/briefing-room/presidential-actions/2021/01/20/executive-order-advancing-racial-equity-and-support-for-underserved-communities-through-the-federal-government/.

K.2.2. Data sources for measuring SDOH

Describe the availability of data for measuring or assessing SDOH as it relates to your MFP Demonstration. Describe barriers to obtaining data on SDOH and how your MFP Demonstration plans to address or overcome these barriers.

Intentionally left blank.

K.3. Tribal Initiative

Indicate whether the state or territory has or is planning a Tribal Initiative within its MFP Demonstration. If it has or will have a program, please complete the next section (Section L). If the state or territory does not have a Tribal Initiative and is not planning one, please respond to the prompts below but do not complete the next section (Section L).

☒ Yes, there is a Tribal Initiative to the MFP Demonstration or one is being planned.

☐ No, there is not a Tribal Initiative to the MFP Demonstration.

If the state or territory does not have a Tribal Initiative and is not planning one, describe why a Tribal Initiative is not needed in the state or territory. Responses should discuss considerations that went into the decision not to have a Tribal Initiative, including whether the state or territory has conducted any outreach to Tribal nations and communities and, if relevant, the outcomes of those outreach efforts.

All information relevant to the Tribal Initiative will be reflected in section L.

K.4. Other information

If needed, provide other information regarding the state or territory's approach to equity that is not addressed elsewhere in the template.

Intentionally left blank.

SECTION L. TRIBAL INITIATIVE

If your state or territory has or is planning a Tribal Initiative, please describe the Tribal Initiative.

L.1. Tribal Initiative project director

Name the project director of the Tribal Initiative, describe the percentage of time the project director spends on this initiative, and offer a brief description of the roles and responsibilities of the position.

Jillian Morris is the Tribal Initiative Project Director (AI/AN outreach coordinator) she dedicates 100% of her time to the development, coordination, collaboration and expansion of LTSS in partnership with Tribal nations. The role includes:

- Strengthening government-to-government collaboration between Tribes, Urban Indian Organizations (UIOs), and state agencies such as Department of Social and Health Services (DSHS), Home and Community Living Administration (HCLA), Health Care Authority (HCA), and Department of Health (DOH).
- Coordinating efforts to address challenges related to licensure, reimbursement, and Medicaid payment structures for long-term services and supports (LTSS).
- Facilitating policy and regulatory discussions to improve access to state-funded LTSS programs.
- Identifying infrastructure gaps and supporting development of sustainable care models that are locally adapted to meet the priorities of the community.
- Development and implementation of locally adapted, tradition-conscious training programs for caregivers and Tribal health providers.
- Ensuring programmatic execution and implementation in alignment with the 7.01 policy per DSHS, the Centennial Accord (1989), and Millenium Agreement (1999) in Washington State regarding Tribal consultation.
- Adheres to the principles outlined in Executive Order 13175- Consultation and Coordination with Indian Tribal Governments (2000), ensuring that all policies, programs, and funding decisions related to Tribal Long-Term Services and Supports (LTSS) are made in consultation with Tribal nations in a manner that respects Tribal sovereignty and self-determination.
- Collect and analyze population projections of AI/AN adults to enable planning for long-term services and support (LTSS) needs.
- Identifying existing LTSS practices and service delivery methods provided in community contexts that require bolstering for sustainability.
- Partner with Office of Indian Policy (OIP) to inform state partners of distinct nuances that the 29 Tribal nations of Washington possess due to the varying locations (urban vs. rural) and land-based resources available.

Objectives:

Expand Medicaid LTSS Access: Ensure individuals in Tribal communities have increased access to Medicaid-reimbursable LTSS

Strengthen Tribal Infrastructure: Support Tribes and Tribal Organizations (T/TOs) in developing the necessary infrastructure to provide and manage LTSS services, either directly or through contracted providers.

Enhance Reimbursement Mechanisms: Develop accessible payment structures to facilitate service delivery, including the pursuit of high Federal Medical Assistance Percentages (FMAP) and encounter rates as outlined in the Federal Register.

Promote Tribal contracting for LTSS: Increase opportunities for Tribal entities to contract with the state for the direct provision of Medicaid-funded LTSS.

Vary Service Delivery Models: Identify pathways for service expansion beyond Medicaid LTSS, including culturally relevant models of care that align with Tribal priorities.

Build Workforce and Training Capacity: Provide education and training opportunities that incorporate locally adapted and tradition conscious caregiving methodologies and pedagogies to support long-term workforce in development.

This initiative is on-going and relationship-driven, requiring sustained collaboration with Tribal Nations and Urban Indian Organizations (UIOs). This best practice is informed by the 7.01 Policy at Washington State Department of Social and Health Services, as well as the Washington State Centennial Accord (19890, and Millennium Agreement (1999). Washington state recognizes the government-to-government principle is inherent when fostering formal and informal working relationships with Tribal nations and serves as the guiding framework for Tribal engagement, conflict resolution and policy integration. These foundational relationships continue to guide the development of adaptable service models that reflect the range of Tribal healthcare systems.

L.2. Capacity building and planning

L.2.1. Federally recognized Tribal nations

Name each of the federally recognized Tribal nations within the state or territory.

In Washington Territory, many treaties were signed in the mid-19th century, leading to the establishment of reservations and the cessation of Tribal lands. There are 29 federally recognized Tribal nations in Washington state. A few of these nations are considered confederated Tribes, meaning there are multiple Tribal nations within one confederation. It is important to understand these nuances for relationship building and fostering meaningful collaboration with Tribal nations. Though many of these nations share similar beliefs, they may have distinct social and historical practices that require consideration when creating locally adapted and tradition-conscious service delivery mechanisms.

Chehalis – The Confederated Tribes of the Chehalis Reservation has more than 800 members and a reservation of approximately 4,400 acres in southwest Washington. Treaty of Olympia (1856)- This treaty involved the Quinault and Quileute tribes, with the Chehalis and other tribes later being associated with the Quinault Reservation.

Colville – The Confederated Tribes of the Colville Reservation is comprised of 12 aboriginal tribes that lived in North Central Washington. The tribe has more than 9,300 enrolled members, about half of whom live on or near the 1.4-million-acre reservation. The Colville Tribes were not signatories to a specific treaty but were relocated to the Colville Reservation established by executive order in 1872.

Cowlitz – The Cowlitz Indian Tribe has been a federally recognized tribe since 2000 and received their first reservation in March 2015. The Cowlitz were not signatories to any of the 1850s treaties. They gained federal recognition in 2000.

Hoh – The Hoh Tribe has 447 acres of reservation land on the Pacific coast at the mouth of the Hoh River. Quinault Treaty (1855): The Hoh were considered a subset of the Quileute tribe and were included in this treaty.

Jamestown S'Klallam – The Jamestown S'Klallam Tribe is located on 13.5 acres along Sequim Bay. Jamestown also has land held in trust outside the reservation and owns land in fee. Treaty of Point No Point (1855): Signed by the S'Klallam Tribe, including ancestors of the Jamestown S'Klallam Tribe.

Kalispel – the Kalispel Tribe of Indians has 4,557 acres along the Pend Oreille River north of Spokane and approximately 40 acres of trust land in Airway Heights. The Kalispel Tribe were given poor terms by the federal government in 1872 which would have ceded more than one million acres, they refused to sign, and the federal government stopped making treaties in 1874. The Kalispel Reservation was established by the President of the United States in 1914.

Lower Elwha Klallam – The Lower Elwha Klallam Tribe is located on roughly 1,000 acres in the northern Olympic Peninsula. Treaty of Point No Point (1855)

Lummi – Lummi Nation is the third largest tribe in Washington with more than 5,000 members and a 13,000-acre reservation. Treaty of Point Elliott (1855): The Lummi were signatories to this treaty.

Makah – The Makah Indian Tribe Reservation is located at Neah Bay at the most northwest point of the continental United States. Treaty of Neah Bay (1855)

Muckleshoot – The Muckleshoot Indian Tribe, with more than 3,000 members, has a reservation in southeast King County. Treaty of Medicine Creek (1854): Ancestors of the Muckleshoot, including the Puyallup and Nisqually. Treaty of Point Elliott (1855): Also relevant to tribes consolidated into the Muckleshoot.

Nisqually – The Nisqually Indian Tribe has more than 650 enrolled members, a majority of whom lives on or near the reservation. Treaty of Medicine Creek (1854): The Nisqually were signatories.

Nooksack – The Nooksack Indian Tribe, with approximately 2,000 members, has a 444-acre reservation located near Deming. Treaty of Point Elliott (1855)

Port Gamble S'Klallam – The Port Gamble S'Klallam Tribe has over 1,200 members and a reservation along Port Gamble Bay near Hood Canal. Treaty of Point No Point (1855)

Puyallup – The Puyallup Tribe of Indians has more than 4,000 members and is considered one of the most urban Indian reservations in the U.S. Treaty of Medicine Creek (1854)

Quileute – Quileute Tribe are located in La Push on the shores of the Pacific Ocean. Quinault Treaty (1855)

Quinault – The Quinault Indian Nation Reservation has over 208,150 acres located at the southwest corner of the Olympic Peninsula and has over 2,500 members. Quinault Treaty (1855)

Samish – The Samish Indian Nation is located near Anacortes. Treaty of Point Elliott (1855)

Sauk-Suiattle – The Sauk-Suiattle Indian Tribe is located near Darrington and has approximately 200 members on its 34-acre reservation. Treaty of Point Elliott (1855)

Shoalwater Bay – The Shoalwater Bay Indian Tribe is located in southwestern Washington on the northwest coast of the Pacific Ocean. Treaty of Olympia (1856)

Skokomish – The Skokomish Indian Tribe is located on a nearly 5,000-acre reservation on Hood Canal at the delta of the Skokomish River. Treaty of Point No Point (1855)

Snoqualmie – The Snoqualmie Indian Tribe has approximately 650 members and is located in the Snoqualmie Valley. Treaty of Point Elliott (1855)

Spokane – The Spokane Tribe of Indians' reservation is 159,000 acres located in Eastern Washington; the tribe has approximately 2,700 members. Treaty of Spokane Plains (1858)

Squaxin Island – The Squaxin Island Tribe is located at the south end of Puget Sound, their reservation includes Squaxin Island and six acres of land at Kamilche, with approximately 930 members. Treaty of Medicine Creek (1854)

Stillaguamish – The Stillaguamish Tribe of Indians has over 230 members in Snohomish County. Treaty of Point Elliott (1855)

Suquamish – The Suquamish Tribe is located on the Port Madison Indian Reservation in North Kitsap County. Treaty of Point Elliott (1855)

Swinomish – The Swinomish Indian Tribe has approximately 900 tribal members, the majority of whom lives within the Swinomish Reservation and Skagit County. Treaty of Point Elliott (1855)

Tulalip – The Tulalip Tribes of Washington is located on the Tulalip Reservation near Everett, the reservation is 22,000 acres, where over half of its 4,000 members live. Treaty of Point Elliott (1855)

Upper Skagit – The Upper Skagit Indian Tribes' reservation has a total land area of 110 acres in Western Skagit County and has approximately 200 members. *The Upper Skagit Indian Tribe does not currently have a working website. Treaty of Point Elliott (1855)

Yakama – The Confederated Tribes and Bands of the Yakama Nation have a reservation with over one million acres located in Central Washington. Treaty with the Yakama (1855)

L.2.2. Engagement with Tribal nations

Describe which tribes are MFP Tribal partners and how the state or territory engages with these partners. Describe how the state or territory engages with tribes that are not MFP Tribal partners. Include strategies and efforts to date and any anticipated or planned engagement efforts.

11 Tribes/Urban Indian Organizations contracted:

- Chehalis Nation
- Lummi Nation
- Makah Tribe
- Muckleshoot Tribe
- Nisqually Tribe
- Nooksack Tribe
- Samish Nation
- Spokane Tribe
- Squaxin Island Tribe

- Quinault Indian Nation
- American Indian Community Center

Institutional Partners: Primary institutional partners that contribute to successful outreach strategies and institutional leadership examples for the initiative include: The Indian Policy Advisory Committee (IPAC), The Department of Social and Health Services (DSHS), Home and Community Living Administration (HCLA), and the Health Care Authority (HCA). Non-tribal organizations provide fundamental mechanisms for disseminating program information, policy and procedural updates, and information regarding Medicaid funded programs to support long-term care. Secondary partnerships may include, Northwest Portland Area Indian Health Board, United Indians of All Tribes, Seattle Indian Health Board.

Indian Policy Advisory Committee (IPAC): The oldest Tribal advisory committee in the state, established in 1977. The IPAC serves as an advisory board to the secretary of DSHS, which is the largest state agency in Washington state.

American Indian Health Commission: Created in 1994, AIHC is comprised of federally recognized Tribes, urban Indian organizations, and other Indian organizations with the goal of improving the health of AI/AN populations by increasing collaboration on health programs and policies that seek to decrease disparities in relation to RCW 43.70.590-American Indian Health Care Delivery Plan.

Office of Indian Policy (OIP): Office of Indian Policy within DSHS provides administrative support and technical assistance to the project director. Through facilitation of the monthly IPAC subcommittee meetings where the MFPTI director coordinates speakers and outreach to Tribal nations in attendance.

The Department of Social and Health Services, through a cooperative agreement with the Health Care Authority, administers long-term services and supports for Medicaid recipients. Both State agencies will participate in the initiative with DSHS/HCLA as the designated MFP lead.

Since 2015, the state has been partnering with Tribes to utilize Money Follows the Person to build capacity that would strengthen their community infrastructure to increase access to long term services and supports. These infrastructures have supported and shaped communities to achieve the goal of keeping elders and/or individuals with a disability in their community. This mechanism saves federal and state spending on long-term care institutionalization.

Outreach and Planned Engagement:

- Medicaid LTSS and HCBS program education- Annual Tribal Summit 1x a year.
- Monthly IPAC subcommittee meetings-presenters share information for Medicaid
- Savvy Caregiver in Indian Country training- in-person and virtual platform
- Annual and/or quarterly 7.01 meetings with participating Tribes
- Monthly Behavioral Health/Health Care Authority Tribal-centric Advisory meeting
- Annual Centennial Accord
- Annual Opioid Summit
- Developing Support to Area Agencies on Aging (AAA's) run by AI/AN nations (Confederated Tribes of the Colville Reservation and Confederated Tribes and Bands of the Yakama Nation).

The department meets routinely (1x per month-3x per month) with AI/AN partners to discuss planning, development and implementation of service delivery models to reach operational, financial or community attunement. Aligning LTSS programs with the strengths of the community (multi-generational care models, informal community support models) aids in achieving goals of the program and the state.

Since 2019, the request for the grant amount has increased from $25,000.00 to $100,000.00. Historically, the department has received an average of three tribes requesting MFPTI contracts. This has since increased to an average of five. In 2024, the department contracted with five tribes and currently within the first quarter of 2025 there are three tribes that have signed contracts with Money Follows the Person Tribal Initiative and two are pending. The department anticipates the demand for contracting to grow with future upward trends of aging adults and the increase of demands for long-term care programs.

A number of formal agreements currently exist between Washington and the Federally Recognized Tribes and/or Recognized American Indian Organizations. Additional supports for a strong working relationship include formal consultation policies for both DSHS and HCA. Through decades of planning, and continuous quality improvement, Washington State's LTSS system is cost effective and quality oriented. The lessons learned in Washington's development of home and community-based services provide foundational excellence for the development of services in AI/AN communities.

L.3. Operations

Describe the operating details of your state or territory's Tribal Initiative. Describe any operational activities that differ from the state or territory's MFP Demonstration in terms of benefits and services available to participants through the Tribal Initiative, quality assurance, self-direction options, housing options for participants, and how continuity of care is maintained after the end of the 365-day Demonstration period.

Include in the MFP Work Plan specific Tribal Initiative objectives including transition benchmarks, outreach to Tribes and Tribal providers, recruitment and enrollment efforts, and workforce development objectives including the amount of services delivered Tribally.

The Tribal Initiative differs from the general MFP demonstration by implementing Tribal-specific objectives focused on:

- Self-directed care options that honor caregiving values reflexive to the community including multi-generational care models.
- Housing and care models that prioritize aging-in-place, Environmental modification contracts prioritize Elders homes and disabled adults at risk of institutional admission without modifications.
- Continuity of care bolstered beyond the 365-day MFP demonstration through community-led adaptations, ensuring long-term sustainability that prevents further institutional living.
- Flexible workforce development programs that integrate caregiving curriculum into local high-school programs that promote trained caregivers within the community.
- Community administered programming. Many Tribes have community health centers that serve Tribal and non-Tribal Medicaid qualified individuals.

TI differs from the MFP demonstration operationally through the interconnected government-to-government framework of Tribal nations, state agencies, health care providers, and community-based organizations.

This initiative requires collaboration and understanding of the government-to-government relationship that is inherent when working with Federally recognized Tribal nations, urban Indian health organizations (UIOs), state agencies, and county-based Area Agencies on Aging (AAAs). The initiative seeks increase access to Medicaid Long-term Services and Supports to individuals who need them, identify and support Tribal infrastructure needs as identified by tribes, to enable Tribes/Tribal Organizations (T/TOs) to provide services directly and/or contract to provide services, development of accessible reimbursement mechanisms for service delivery, identification of opportunities to obtain higher federal medical assistance percentages (FMAP) and/or encounter rates as defined in the federal register, expand opportunities for Tribal Contracting for direct service delivery of Medicaid reimbursed LTSS, diversify opportunities outside of LTSS Medicaid for service delivery, and seek out training and education opportunities that support culturally grounded methodology and pedagogy for caregiving in AI/AN communities. This is an ongoing initiative that focuses on building relationships and outreach to AI/AN nations, and UIOs in Washington state.

Tribes that have contracted under the MFPTI grant have been successful in obtaining access to long term programs that benefit their elders and individuals with disabilities. They have implemented Community Health Representatives (CHR) within their community to implement the following programs:

- Health Homes to improve coordination of care, quality and increase the individual's participation in their own care.
- Lifespan Respite is a resource for unpaid caregivers that provides respite care while the primary caregiver needs time to run errands or is temporarily unavailable for a short period of time.
- Home Delivered Meals expansion to address food scarcity for elders living in rural communities or do not have the capacity to travel to obtain meals.
- Home Care Agencies which provide in-home caregiving services.
- Contract for environmental modification to provide a safe living environment to elders within their community.
- Introduced High School Home Care Aide program for students to graduate with a Home Care Aide Certificate. This addresses direct care workforce for in-home providers and health care workers within tribal communities.

These are just a few examples of successful AI/AN adaptation of programs that are offered within HCLA.

The Tribal Initiative Project Manager coordinates department and tribal meetings that has benefited tribes in developing relationships with Adult Protective Services (APS), Traumatic Brain Injury (TBI) Council, Dementia Action Collaboration (DAC) Committee, Office of Superintendent of Public Instruction (OSPI) and local community health networks.

L.4. Other information

If needed, provide other information regarding the state or territory's approach to Tribal Initiatives that is not addressed elsewhere in the template.

According to the PEW Research Center, about 10,000 Americans turn 65 every day. This trend is expected to continue for the next several decades and is referred to as "the silver tsunami" and has major implications for America such as the need for the following:

- Greater demand for healthcare and long-term care.
- A shortage of individual providers to be caretakers.

The importance of risk reduction interventions that can delay or prevent the demand for long-term services in the future for elders is greater now than it was in the past. Some factors that impact AI/AN compared to other individuals are diabetes, hypertension, traumatic brain injury, social isolation and effects of long-term substance use.

Tribal initiative has supported evidence-based training programs to administer health education for caring for individuals that may have been diagnosed with Alzheimer's and dementia related diseases. This training is invaluable to family members that are caring for their loved ones in the home or working as a respite provider within the community. The tribal initiative project manager developed the curriculum to build a free training program adapted for AI/AN communities through available resources for respite training.

Lastly, as the state and the entire Nation tackles substance use prevention, the tribal initiative project manager collaborates with TBI, DAC, and HCA in a supportive role as AI/AN nations experience substance and drug related health problems disproportionately. The growing threat of opioids to all communities exacerbate the impacts of long-term health issues on the long-term care system. Sustained drug use, and usury behaviors (job loss, connection to family lost, incarceration etc.) impact even those in recovery and may result in varying levels of engagement to long-term care and supportive services due to the residual side effects of substance use.

The Tribal Initiative under the Money Follows the Person (MFP) demonstration aims to enhance access to Medicaid Long-Term Services and Supports (LTSS) for American Indians/Alaska Natives by strengthening Tribal infrastructure and service delivery mechanisms. The initiative is guided by a nation-to-nation approach, recognizing the unique governance and healthcare delivery needs of the 29 federally recognized Tribes and Urban Indian Organizations (UIOs) in Washington State.

SECTION M. PUBLIC HEALTH EMERGENCIES

M.1. Program adaptations in response to Public Health Emergencies

M.1.1. Program adaptations

Describe adaptations your state or territory's MFP Demonstration made in response to a Public Health Emergency (PHE), such as the COVID-19 PHE, declared at either the state, territory, or federal level. For instance, these could include protocols for MFP participants living in the community who test positive for COVID-19, plans to prevent COVID-19 spread among participants, modifying recommendations related to infection control or immunizations (such as the COVID-19, flu, and shingles vaccines), or ways the MFP Demonstration has expanded access to or incorporated services delivered through telehealth technology. Identify adaptations that have ended and those that are ongoing. Describe how any MFP Demonstration adaptations in response to PHEs align with and use policies and procedures from the state or territory's HCBS program(s).

In response to Public Health Emergencies (PHEs) such as COVID-19, the state implemented various adaptations to ensure continuity of care and minimize the spread of the virus. These adaptations were applied universally to all Medicaid clients, rather than being specific to MFP participants. In addition, DSHS followed guidance and adhered to local, state and federal recommendations to ensure alignment during the pandemic.

Medicaid Eligibility Adjustments:

- To reduce barriers to accessing Medicaid services, DSHS implemented presumptive eligibility and continuous enrollment throughout the public health emergency, ensuring uninterrupted access to care. The department has adapted an ongoing presumptive eligibility process.
- The department allowed for delays in annual functional level of care comprehensive assessments, which ended 12/31/2022. Now all annual comprehensive assessments will need to be done by their plan period end date.
- Expanded housing maintenance flexibilities to allow for coverage at 100% of the Federal Poverty Level with a physician's certification that the Medicaid resident is likely to return to the home within a 6-month period. This applies to all clients who admitted to a nursing facility under Medicaid on or after March 18, 2020 and contributes towards their cost of care. This expansion to the housing maintenance flexibilities is ongoing.

HCBS Delivery Enhancements:

- Adopted remote comprehensive assessments delivery through telephone or other technology during the PHE to ensure ongoing access to services which ended July 2021.
- Allowed for verbal consent by the client in order to implement the plan of care and the provider responsible for implementing the client's plan of care through the end of the public health emergency. As a response, voice signature adaptations were introduced to facilitate remote service approval.
- The state implemented pandemic-related extraordinary service add-on enhanced rates to service providers during the pandemic. These rates were incrementally reduced and were phased out June 30, 2024.

Infection Control

- DSHS made purchases of PPE and distributed PPE to Individual Providers (IPs) and Adult Family Homes.
- DSHS created a rapid response team of clinical nursing staff to provide temporary direct care to licensed LTSS settings when the facility's staff had to quarantine and dropped to critical levels.
- DSHS created specialty COVID-19 Cohort contracts with Nursing Facilities across the state, to support transitions out of acute hospitals and to prevent the spread of the contagion. DSHS provided fit testing, PPE, and clinical nursing staff support to these facilities until the vaccine was widely available.
- Prior to COVID-19, pneumococcal and flu vaccinations were encouraged and screened for during each comprehensive assessment. With the emergence of COVID-19, these efforts were expanded to include encouragement and screening for the COVID-19 vaccine, which was incorporated and remains in our comprehensive assessment tool.
- DSHS purchased a skilled nursing facility as part of the statewide response to COVID-19 crisis. While initially acquired for COVID-related needs, DSHS intends for this facility to serve as an ongoing resource for hospital patients who face discharge challenges.

M.2. Future PHEs

Describe if and how your state or territory is planning for future PHEs in its HCBS systems and MFP Demonstration. For instance, this may include permanent adoption of measures implemented for the COVID-19 PHE.

Emergency preparedness is essential for ensuring the safety and well-being of all Washingtonians, including our MFP participants. Washington State takes a comprehensive approach to PHEs, ensuring a coordinated response through our various emergency management departments and partnered agencies.

More information on our emergency response efforts can be found below:

Partnered Agencies:

Washington State-Emergency Management Division

Northwest Healthcare Response Network

Washington State Department of Health-Emergencies

Additional Emergency Preparedness Resources:

Resources for Long-Term Care Facilities - Emergency Planning

Continuum of Care Decisions for Critical Staffing Management in Long-Term Care Settings Guide

Emergency Preparedness Workbook for Adult Family Homes

DDA Emergency Preparedness

Washington has implemented the utilization of MFP supplemental and qualified services to provide Technology Support Consultation and Technical Assistance. Many within the MFP target populations would benefit from broadband access to deliver services, such as telehealth, which can directly improve health and life outcomes in community settings, especially for those who otherwise lack access to

medical providers. However, these benefits can only be maximized when participants have physical access to networks, can afford a subscription and equipment, and have the skills to use broadband related services and assistive technology supports. For those MFP participants who receive an assistive technology device to reduce isolation, support safety and promote independence, the Assistive Technology Consultant and Technical Assistance provider will be required to set up and provide instruction on how to use the device to reduce human assistance with medical appointments (telehealth), health related tasks, communication needs, and the IADLs of grocery delivery and arranging transportation.

In addition, DSHS has adopted remote caregiving, which is a flexible and innovative solution designed to provide personal care to clients through an interactive screen. Caregivers assist with non-hands-on tasks like medication reminders and task cueing, while in-person care is available for tasks requiring physical presence.

Washington State's permanent adoption of measures which were implemented during the COVID-19 PHE are detailed in Section M.1.1.

M.3. Other information

If needed, provide other information regarding the state or territory's approach to PHEs that is not addressed elsewhere in the template.

Not applicable

APPENDIX A. HYPERLINKS AND GLOSSARY

States or territories may include additional information and documents that do not fit in the other template sections in the Appendix. The template provides default appendix section and subsection headings that states or territories may rename, delete, or otherwise modify as needed. States or territories may also modify the appendix section titles to meet their needs. States or territories that include hyperlinks in the OP must collect all links in the reference table below.

App A.1. Summary of Hyperlinks

Copy all hyperlinks used in the OP into the table below, by OP section. For each link, provide a brief description (for example, “educational materials provided to participants”).

Appendix Table A.1. Summary of Hyperlinks

OP section	Link	Brief description
How to use	Embed or link to a file in Word	Instructions for embedding a file in a Word document
	Make your Word documents accessible to people with disabilities	Accessibility instructions for Word documents
A. MFP program overview	NH Facility Search	Nursing Facility Search Tool maintained by the regulatory oversight division: Residential Care Services
	Skilled Nursing Facilities Map.pdf	Skilled Nursing Facility Access Map. Displays Number of paid Medicaid Clients, Number of Medicaid Contracted Nursing Facilities and total Nursing Facility licensed beds.
	Nursing Facility Transitions with Home and Community Based Services	Online brochure outlining services available to SNF residents to support transition planning.
	Aging and Long-Term Support Strategic Goals | DSHS Developmental Disabilities Strategic Goals | DSHS	Website listing the strategic goals of DSHS.
	State of Washington Olmstead Plan-2024	Washington State Olmstead Plan.
	Residential Care Lookup	Supported Living Program Locator-DDA

OP section	Link	Brief description
B. Project administration	Roads to Community Living | Washington State Health Care Authority	Health Care Authority (Medicaid Agency) website about the Roads to Community Living Program.
	https://www.hca.wa.gov/about-hca/who-we-are/our-leadership	Health Care Authority Website showing Medicaid Agency Director and leadership.
	https://www.dshs.wa.gov/sites/default/files/os/org-charts/DSHS-Orgchart.pdf	Department of Social and Health Services Organization Chart
	https://www.dshs.wa.gov/sites/default/files/os/org-charts/HCLA-Orgchart.pdf	Home and Community Living Administration Organizational Chart
	WAC 182-513-1100: Definitions related to LTSS	Defines that HCBS Programs are administered under HCLA and DDA, two administrations under "The Department" of Social and Health Services (DSHS).
	WAC 182-513-1200: LTSS Authorized under Washington Apple Health Programs	Provides Washington Administrative Code authority for LTSS Delivery under Medicaid Medical Programs (referred to as Apple Health). HCBS is administered by "the Department."
	WAC 182-513-1235: Roads to Community Living	RCL Eligibility and program under Long-Term Care Services Washington Administrative Code (WAC).
	Chapter 388-71 WAC: Home Care Agency Provider Qualifications	Washington Administrative Code outlining Home Care agency Qualifications

C. Recruitment, enrollment, outreach, and education	HCS-Roads to Community Living (RCL) | DSHS DDA-Roads to Community Living | DSHS	Resource website for recruitment, enrollment, outreach and education for participants and interested community members.
	Apple Health and Long Term Services and Supports Brochure	Educational materials provided to participants interested in LTSS.
	Transition Resource Brochure	One-page resource Preparing to Transition from a Nursing Home.
	Client Information and Resources | DSHS	Client Information and Resources website
	Community Living Connections	Washington Residents can learn about and access the full range of private and public Long-term services and supports
	Long-Term Care (LTC) Manual: Chapter 3	The Long-Term Care (LTC) Manual documents policy and procedure for HCS, AAA, and DDA. This chapter covers Assessment and Care Planning.
	Acknowledgement of Services (DSHS Form 14-225)	DSHS Form 14-225
	Consent to Release Information (DSHS Form 14-012)	DSHS Form 14-012
	Rights and Responsibilities When You Receive Services from ALTC and DDA	Rights and Responsibilities when you receive services offered by Home and Community Living Administration and Developmental Disabilities Administration.
	RCL Brochure DDA RCL Website Tribal Affairs MFP Website RCL Newsletter Subscription Sign Up RCL Video RCL Fact Sheet DDA RCL Fact Sheet HCLA LTC Care Manual Chapter 29: Roads to Community Living Nursing Home Guidelines (The Purple Book)	Educational Materials provided to individuals who are MFP participants or interested in learning about transitioning from an institutional setting to HCBS.
	Nursing Facility Transitions with HCBS	A brochure that provides information regarding HCBS services and supports available for individuals transitioning out of institutional settings.
	State of Washington Olmstead Plan	Washington State Olmstead Plan

OP section	Link	Brief description
	Web Content Accessibility Guidelines	Website that outlines Web Content Accessibility Guidelines (WCAG) 2.1. This guideline covers a wide range of recommendations for making Web content more accessible.
	Choosing Care in an Adult Family Home or Assisted Living Facility	Brochure that provides information to individuals who are choosing an adult family home or assisted living facility.
	22-619 Medicaid and LTSS for Adults	Brochure that provides information on applying and receiving Apple Health LTSS, care options, and caregiver assistance options.
	RCW 7.70.065: Informed consent—Persons authorized to provide for patients who do not have capacity—Priority—Unaccompanied homeless minors.	RCW describing informed consent parameters for alternate decision makers.
	Chapter 11.130 RCW: UNIFORM GUARDIANSHIP, CONSERVATORSHIP, AND OTHER PROTECTIVE ARRANGEMENTS ACT	Chapter for Uniform Guardianship and other protective arrangements. 11.130.001-RCW 11.130.915
D. Community engagement	Stakeholders | DSHS	List of Stakeholders working with HCLA
	Service Experience Team (SET) | DSHS	SET is an advisory Council comprised of individuals who are receiving HCBS.
	Office of Housing and Employment | DSHS	OHAE website provides affordable housing information and resources.
E. Benefits and services	March 31, 2022 Note to MFP Recipients	Note to MFP Recipients: Announcement of Certain Changes to Supplemental Services under the MFP Demonstration
	AAA Directory.docx	Directory of the 13 Area Agencies on Aging and the counties within their geographical areas.
	Information for Potential Medicaid Contractors | DSHS	Website for prospective HCBS contracted provider applications. This lists all scopes of work and qualifications for each contracted service.

OP section	Link	Brief description
F. Transition and housing services	https://www.medicaid.gov/federal-policy-guidance/downloads/sho21001.pdf	State Health Official letter #21-001 RE: Opportunities in Medicaid and CHIP to Address Social Determinants of Health (SDOH)
	Long-Term Care (LTC) Manual: Chapter 3 Long-Term Care (LTC) Manual: Chapter 5	Website: The Long-Term Care (LTC) Manual documents policy and procedure for HCS, AAA, and DDA. This chapter covers Assessment and Care Planning.
	ALTSA's Strategic Plan	Outlines ALTSA's specific goals, along with action plans and success measures.
	DDA Policy 3.03	Transitional care management policy 3.03
	22-1984 Transitioning to a New Home	Transition Social Story – "Transitioning to a New Home": An illustrated, interactive tool
	22-2023 Choose Your Path	Interactive tool for person centered planning
	Office of Housing and Employment | DSHS	Office of Housing and Employment Website
G. Self-direction and informal caregiving	RCW 74.39.050: Individuals with functional disabilities—Self-directed care.	Functional Eligibility for Self-Directed Care
	RCW 74.39.007: Definitions.	Definition of Self-directed care and personal aide
	Home - Consumer Direct Care Network Washington	Online portal for Consumer Direct Care Network Washington to access Individual Providers (IP) who provide in-home personal care and respite services.
	Caregiver Resources | DSHS	Informational website for caregivers
	Self directed Care brochure	Education material
H. Reporting		

I. Quality measurement, assurance, and monitoring	WA COPES Waiver (0049.R09.00) | Medicaid	The CMS Approved quality improvement system-appendix H of the COPES 1915(c) Waiver
	HCBS Quality Measure Set	Information about the HCBS Quality Measure Set
	Adult Protective Services	DSHS Adult Protective Services website
	WAC 388-113-002 DSHS Criminal History Background Check	Identifies which criminal convictions and pending charge automatically disqualify an individual from having unsupervised access to clients
	Online Abuse Reporting System Reporting Concerns Involving Vulnerable Adults	Online reporting portal to report concerns involving vulnerable adults.
	Reporting Concerns Involving Vulnerable Adults by Phone	Resource for how to report concerns involving vulnerable adults by phone
	DSHS Form 16-172 Your Rights and Responsibilities	Your Rights and Responsibilities When You Receive Services Offered by Home and Community Living Administration and Developmental Disabilities Administration
	End Harm Campaign	One-page flier explains how to report abuse or neglect of a child or vulnerable adult. Available in several languages.
	DOH Local Health Jurisdictions	Department of Health Jurisdiction locator for each county of Washington
	DOH Emergency Medical Services	Department of Heath Jurisdiction website for Emergency Medical Services
	Health Care Authority Medical Transportation Brokerage List	Health Care Authority Medical Transportation website for statewide medical transportation brokerage lists
	Consumer Direct Care Network Washington (CDWA)	Online portal for Consumer Direct Care Network Washington to access Individual Providers (IP) who provide in-home personal care and respite services.
	Community Health Plan of Washington Coordinated Care Molina Healthcare of Washington United Healthcare Community Plan Wellpoint Washington	State managed Medicaid plans resource to explore Medicaid benefits
	Intuition Robotics-ElliQ	Smart Care Companion service provider resource

OP section	Link	Brief description
	E911 | Washington State Military Department, Citizens Serving Citizens with Pride & Tradition	Emergency Management Division oversees the WA state 911 Program.
	Long-Term Care (LTC) Manual: Chapter 3	Website: The Long-Term Care (LTC) Manual documents policy and procedure for HCS, AAA, and DDA. This chapter covers Assessment and Care Planning.
	Advocacy for Long-Term Care Residents | Federal Way, WA | Washington State Long-Term Care Ombudsman Program	LTC Ombuds Program and consumer education website
	HOME | OBHA	The Office of Behavioral Health Advocacy website-provides Mental Health Ombuds program
	DDA Roadmap to Resolution.pdf	Brochures outlining the DDA Complaint and resolution process.
J. Continuity of care post-Demonstration	Section 6071(c)(2) of the Deficit Reduction Act	Requirement that the MFP project must operate in conjunction with a qualified and operational HCBS program
K. Equity	Executive Order on Advancing Racial Equity and Support for Underserved Communities Through the Federal Government	Definition of equity
L. Tribal Initiative	Money Follows the Person | DSHS	Washington State MFP Tribal Initiative Website
	The Tribes of Washington - Washington Tribes	Map of Federally Recognized Tribes of Washington.
	RCW 43.70.590: American Indian health care delivery plan.	Revised Code of Washington for American Indian healthcare delivery Plan

OP section	Link	Brief description
M. Public health emergencies	Washington State-Emergency Management Division	The Washington Emergency Management Division leads and coordinates mitigation, preparedness, response and recovery in Washington State to minimize the impact of disasters and emergencies on the people, property, environment and economy.
	Northwest Healthcare Response Network	The Northwest Healthcare Response Network has led a coalition of public and private healthcare, public health and emergency response partners to prepare for, mitigate, respond to and recover from emergencies, disasters and other disruptive events.
	Washington State Department of Health-Emergencies	The Department of Health works with others to protect and improve the health of all people in Washington state.
	Resources for Long-Term Care Facilities-Emergency Planning	This page offers comprehensive resources to support administrators, healthcare professionals, and caregivers in developing an Emergency Preparedness program.
	Continuum of Care Decisions for Critical Staffing Management in Long-Term Care Settings Guide	This document is a tool to help LTC settings consider options when faced with critical staffing crises related to an emergency, disaster, or public health emergency.
	Emergency Preparedness Workbook for Adult Family Homes	This document outlines a standardized approach to basic emergency preparedness for Adult Family Homes (AFH) anywhere in the State of Washington.
	DDA Emergency Preparedness	This document is a tool to help individuals assess their emergency preparedness.
Appendix A		
Appendix B		

App A.2. Glossary

Use the glossary section of the appendix to provide a comprehensive list of acronyms used by the state or territory in responses throughout the OP. Commonly used acronyms are already defined in the glossary table. As demonstrated in the example table shell below (Appendix Table A.2), the glossary can also be used to provide additional context for certain acronyms through brief descriptions.

Appendix Table A.2. Glossary

Acronym	Meaning	Brief description (optional)
AAA	Area Agencies on Aging	
ACES	Automated Client Eligibility System	
ADL	Activity of daily living	
AFH	Adult Family Home	
AIHC	American Indian Health Commission	
AI/AN	American Indian/Alaska Native	
ALTSA	Aging and Long-Term Support Administration	
APS	Adult Protective Services	
BH-ASO	Behavioral Health administrative services organization	
CARE	Comprehensive Assessment and Reporting Evaluation	
CCG	Community Choice Guide	
CHAI	Consolidated Housing Assistance and Information	
CHR	Community Health Representative	
CMS	Centers for Medicare & Medicaid Services	
CSO	Community Services Office	
DAC	Dementia Action Collaboration	
DDC	Developmental Disabilities Council	
DDA	Development Disabilities Administration	Administration under the Department of Social and Health Services.
DME	Durable Medical Equipment	
DPOA	Durable Power of Attorney	
DSHS	Department of Social and Health Services	
DVR	Division of Vocational Rehabilitation	
FFS	Fee-for-service	
FMAP	Federal Medical Assistance Percentage	
FMR		
HAP	Housing Assistance Payment	
HCA	Health Care Authority	The Medicaid Agency for WA
HCS	Home and Community Services	Division within Home and Community Living Administration.
HCBS	Home- and community-based services	
HCLA	Home and Community Living Administration	
HHS	Health and Human Services	
HMA	Home Maintenance Allowance	
HQ	Headquarters	
HSPA	Housing services partnership accelerator	
HUD	Housing and urban development	

Acronym	Meaning	Brief description (optional)
I/DD	Intellectual and developmental disabilities	
IADL	Instrumental activities of daily living	
ICF/IID	Intermediate Care Facility for Individuals with Intellectual Disabilities	
IMD	Institution for Mental Diseases	
IP	Individual Provider	
IPAC	Indian Policy Advisory Committee	
LEP	Limited English Proficiency	
LGBTQ+	Lesbian, gay, bisexual, transgender, and queer	
LTC	Long-Term Care	
LTSS	Long-term services and supports	
LTSS	Long Term Services and Supports	
MCO	Managed Care Organization	
MCP	Managed care plan	
MCP	Managed care plans	
MDS	Minimum Data Set	
MFP	Money Follows the Person	
MFPTI	Money Follows the Person Tribal Initiative	
MH/SUD	Mental health and substance use disorders	
MLTSS	Medicaid managed long-term services and supports	
MLTSS	Managed Long Term Services and Supports	
MMIS	Medicaid Management Information System	
NCI-AD	National Core Indicators- Aging and Disabilities	
NFCM	Nursing Facility Case Manager	
NSA	Necessary Supplemental Accommodation	
NSPIRE	National Standards for the Physical Inspection of Real Estate	
NWD	No Wrong Door	
OHAE	Office of Housing and Employment	
OIP	Office of Indian Policy	
OP	MFP Operational Protocol	
OSPI	Office of Superintendent of Public Instruction	
PD	Physical disabilities	
PHE	Public health emergency	
PRISM	Predictive Risk Intelligence System	
PTC	MFP Program Terms and Conditions	

Acronym	Meaning	Brief description (optional)
QIS	Quality improvement system	
QMS	Quality Management System	
RAC	Recipient Aid Category	
RAIOS	Recognized American Indian Organizations	
RCL	Roads to Community Living	The MFP program in WA State
RCS	Residential Care Services	
RFTA	Request for Tenancy Approval	
SAR	MFP Semi-Annual Progress Report	
SDOH	Social determinants of health	
SMD	State Medicaid director	
SNF	Skilled Nursing Facility	
SOLA	State operated living alternative	
SPA	State Plan Amendment	
STC	Standard Terms and Conditions	CMS's standard grant/cooperative agreement terms and conditions, which can be used as a reference for definitions for key terms.
STRA	Short term rental assistance	
SUD	Substance use disorder	
T-MSIS	Transformed Medicaid Statistical Information System	
T/TO	Tribes and Tribal Organizations	
TBI	Traumatic Brain Injury	
UIO	Urban Indian Health Organizations	
UW	University of Washington	
WA	Washington State	
WHCA	Washington Health Care Association	
WP	MFP Work Plan	
SOLA	State operated living alternative	
SPA	State Plan Amendment	
STC	Standard Terms and Conditions	CMS's standard grant/cooperative agreement terms and conditions, which can be used as a reference for definitions for key terms.
STRA	Short term rental assistance	
SUD	Substance use disorder	
SOLA	State operated living alternative	
SPA	State Plan Amendment	
STC	Standard Terms and Conditions	CMS's standard grant/cooperative agreement terms and conditions, which can be used as a reference for definitions for key terms.
STRA	Short term rental assistance	
SUD	Substance use disorder	
T-MSIS	Transformed Medicaid Statistical Information System	
T/TO	Tribes and Tribal Organizations	

Acronym	Meaning	Brief description (optional)
TBI	Traumatic Brain Injury	
UIO	Urban Indian Health Organizations	
UW	University of Washington	
WA	Washington State	
WHCA	Washington Health Care Association	
WP	MFP Work Plan	

App A.3. Appendix Section

App A.3.1. Appendix subsection

App A.4. Appendix Section

App A.4.1. Appendix subsection

App A.5. Appendix Section

App A.5.1. Appendix subsection

App A.5.1.1. Appendix sub-subsection

APPENDIX B. OPTIONAL SECOND APPENDIX

App B.1. Appendix Section

App B.1.1. Appendix subsection

App B.2. Appendix Section

App B.2.1. Appendix subsection

App B.3. Appendix Section

App B.3.1. Appendix subsection

App B.4. Appendix Section

App B.4.1. Appendix subsection

App B.5. Appendix Section

App B.5.1. Appendix subsection

App B.5.1.1. Appendix sub-subsection