PART II – Chapter 1800

POLICIES AND PROCEDURES
for
ELDERLY AND DISABLED WAIVER
EDWP- (CCSP/SOURCE)
TRADITIONAL/ENHANCED
CASE MANAGEMENT



GEORGIA DEPARTMENT OF COMMUNITY HEALTH

DIVISION OF MEDICAID

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Policy Revisions included in the October 2023 Edition of the EDWP Policy Manuals

Revision Date	Section	Revision Type	Revision Description	Citation
10/1/23	1824/1842/1885	Update	Updates policy re member phone contact, camera telehealth modality and system encryption needs.	DCH Program Policy
10/1/23	1826	Update	Clarifies policy re AHS LOC validation.	DCH Program Policy
10/1/23	1836	Update	Updates policy regarding SOP for MDS uploads to AHS.	DCH Program Policy
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Revision Date	Section	Revision Type	Revision Description	Citation
7/1/23	1801	Update	Adds Assistive Technology as a waivered service.	DCH Program Policy
7/1/23	1803	Update	Adds Assistive Technology as a waivered service.	DCH Program Policy
7/1/23	1821	Update	Updates policy that HDM, Case Management and AT cannot stand alone as the only waivered care received. Updates needed hospice collaborative documentation.	DCH Program Policy
7/1/23	1842	Update	Permits a telehealth visit for modified assessment to add ERS. Clarifies policy regarding member transfers and staff visit requirements.	DCH Program Policy
7/1/23	1851	Update	Clarifies PA information on transfers.	DCH Program Policy

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Revision Date	Section	Revision Type	Revision Description	Citation
4/1/23	1819, 1823 + 1860	Update	Updates address for DCH waiver unit and General Counsel.	DCH Program Policy
4/1/23	1821	Update	Updates ECM Medical Director meeting requirements.	DCH Program
4/1/23	1836	Update	Clarifies SOP for LOC/RN approval.	DCH Program Policy
4/1/23	1844	Update	Updates language re ‘reassessment’ and ‘modified’ term re meal addition.	DCH Program Policy

4/1/23	1872	Update	Removes language re CD PSS and Relative caregiver.	DCH Program Policy
4/1/23	1874	Update	Removes language re CD PSS and Relative caregiver.	DCH Program Policy
4/1/23	1875	Update	Removes language re CD PSS and Relative caregiver.	DCH Program Policy

Policy Revisions included in the January 2023 Edition of the EDWP Policy Manuals

Revision Date	Section	Revision Type	Revision Description	Citation
1/1/23	1823	Update	Removes policy reference to needed appendix Y for enrollment into Case Management.	DCH Program Policy
1/1/23	1836	Update	Updates SOP policy re members losing SSI and the needed gateway process SOP and rebroking of case management.	DCH Program Policy
1/1/23	1842	Update	Clarifies language re service order and care plan review.	DCH Program Policy

PART II –
POLICIES AND PROCEDURES
FOR
THE ELDERLY AND DISABLED WAIVER
TRADITIONAL/ENHANCED CASE MANAGEMENT

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PREFACE

TRADITIONAL/ENHANCED Case Management

Policies and procedures in this Chapter apply to all Elderly and Disabled Waiver, Traditional/Enhanced EDWP Case Management Services. This Chapter must be used in conjunction with the manuals listed below:

Part I – Policies and Procedures for Medicaid/Peach Care for Kids, Chapters 100 through 500

Part II – Chapters 600 – 1000 Policies and Procedures for EDWP General Services Program (CCSP/SOURCE) General Manual

PART II - CHAPTER 1800

1801 -THE ELDERLY AND DISABLED WAIVER PROGRAM

TRADITIONAL/ENHANCED POLICY STATEMENT

The Elderly and Disabled Waiver Program (EDWP)/Traditional/ Enhanced provides Medicaid-funded, community-based services to eligible functionally impaired individuals as an alternative to institutional placement.

POLICY BASICS

The purpose of the Traditional/ Enhanced EDWP is to assist those who are aged (65 and older) and/or functionally impaired or under 65 with a primary physical disability live dignified and reasonably independent lives in their own homes or in homes of relatives or caregivers.

Enabling legislation for the Traditional/ Enhanced EDWP includes: the 1982 Community Care and Services for the Elderly Act and the federal 1981 Omnibus Budget Reconciliation Act establishing the federal 1915(c) Home and Community-Based Services Medicaid Waiver Program.
Protection of client rights is an integral feature of the program.

The program supports the following for people with functional impairments:

- A continued ability to live in the community while receiving services
- A continued choice in living arrangements and kinds of services received.

The Traditional/ Enhanced EDWP is based on the premise that it is desirable to enable functionally impaired persons to reside at home or with their families. Some individuals, however, require more care than can be provided at home or in the community; therefore, it is not always possible or feasible to prevent or delay institutional placement.

Traditional/ Enhanced EDWP goals are achieved through the development of a system of community health and social services which provide a continuum of care for functionally impaired clients to assure that the least restrictive living arrangement is used to maintain independence and safety in the community.

Access to the Traditional/ Enhanced EDWP is achieved through determination of financial eligibility by the county Division of Family and Children Services (DFCS) and an assessment of the individual's need for long term care using criteria established for nursing home placement. The eligibility/assessment function is carried out by the Area Agencies on Aging and the Case Management agencies.

The Traditional/ Enhanced EDWP utilizes a Case Management process that includes telephone screening, assessment, brokering of services, reassessment, and an array of in-home and community-based services designed to prevent unnecessary or premature institutional placement.

Traditional/ Enhanced EDWP services include the following:

- Adult Day Health
- Alternative Living Services
- Assistive Technology
- Emergency Response
- Home Delivered Meals
- Home Delivered Services
- Personal Support/Extended Personal Support
- Out-of-Home Respite
- Traditional Case Management (TCM) + Enhanced Case Management (ECM)

State, federal, and local agencies and businesses coordinate with each other to deliver services to Traditional/ Enhanced EDWP clients. Service delivery occurs at the local level.

The Department of Community Health (DCH) administers the program. AAAs/ Case Management offices provide for local program management and coordination.

Service providers approved by the Department of Community Health deliver Traditional/ EDWP services. Enrolled service providers also submit claims to DCH for payment.

The program may not discriminate or permit discrimination against any person or group of persons on the grounds of age, race, sex, color, religion, national origin, or handicap, in accordance with Title VI of the Civil Rights Act of 1964, as amended, and Section 504 of the Rehabilitation Act of 1973.

PROCEDURES

A telephone screening specialist at the AAA ADRC completes a telephone screening to determine a referral's potential eligibility for Traditional/ Enhanced EDWP and to establish priority for initial assessment.

A nurse uses a standard format to complete initial assessments to determine eligibility for Traditional/ Enhanced EDWP services. During assessment, the Case Management (RN) determines whether a client meets the eligibility criteria and service(s) needed by a client. Alliant Health Solutions (AHS) attests to level of care eligibility and confirms the client appropriateness for services in the community. The applicant's physician provides medical information which the Case Management uses to complete the plan of care and determine whether the applicant meets the level of care criteria for nursing facility placement. Upon a physician's concurrence, Case Management implements the recommended care plan developed at the time of assessment.

The Case Management authorizes, brokers and manages services for a client to assure that the most appropriate services are provided in a timely and cost effective manner. Enrolled service providers deliver the services needed by a client. Case Management arrange non- Medicaid services as needed through other community resources.

The Case Management routinely reviews each client's care plan and adjusts it depending upon changes in a client's condition or circumstances. The Case Management reassesses each

EDWP client and re determines a client's level of care at least annually.

1802 – The 1981 OMNIBUS BUDGET RECONCILIATION ACT

POLICY STATEMENT

The federal 1981 Omnibus Budget Reconciliation Act (OBRA) established funding for the EDWP through the 1915(c) Home and Community-Based Services Medicaid Waiver Program.

POLICY BASICS

The Home and Community-Based Services Medicaid Waiver Program allows states to provide non-institutional services, reimbursable by Medicaid, to individuals at risk of institutional placement or who are receiving institutional care and need help in returning to the community.

PROCEDURES

To participate in a Medicaid waiver program, states apply to the Centers for Medicaid and Medicare Services (CMS) for a Medicaid waiver.

In designing waiver programs, states are allowed to:

- Identify a target population to be served
- Limit participation to specific ages, diagnoses, and geographic areas
- Limit the total number of persons to be served
- Include social services which would ordinarily be excluded from Medicaid coverage
- Provide Medicaid services to persons who would otherwise be ineligible.

CMS approves Medicaid waivers for states which provide the following:

- Safeguards to protect the health and welfare of participants
- Evaluation of applicants to determine eligibility for nursing home care, and assessment of those who meet this level of care test
- Choices for applicants between waivered services and nursing home care
- Assurance that average per capita expenditure for medical assistance with the waiver is not greater than average per capita expenditure would be without the waiver.

1803 – WAIVERED SERVICES

POLICY STATEMENT

Traditional/ Enhanced EDWP clients receive certain services, not normally reimbursable by Medicaid, as set forth in the federal 1981 Omnibus Budget Reconciliation Act. These services are called “waivered services”.

POLICY BASICS

Traditional/ Enhanced EDWP waivered services are reimbursable by Medicaid (Title XIX). However, services that are reimbursed for clients in the Medicaid waiver may also be provided

from a number of funding sources including:

- Older Americans Act, Title III
- Social Services Block Grant (SSBG)
- Medicare.

Traditional/ Enhanced EDWP waivered services include the following:

- Adult Day Health (ADH) - Care for dependent adults in a supervised, protective congregate setting during some portion of a 24-hour day. Services typically include therapeutic activities, dietary services, rehabilitation, medication monitoring and personal care.

- Alternative Living Services (ALS) - 24-hour supervision, medically-related personal care, nursing supervision and health- related support services in state-licensed personal care home.

- Assistive Technology (AT)- Goods and Services that are not otherwise covered by Medicaid State Plan services. These goods and services address the AT needs of the member that result from his/her disability. AT consists of technology that is used to maintain or improve functional capabilities of waiver recipients by augmenting strengths and providing an alternative mode of performing a task.

- Emergency Response System (ERS) - an in-home electronic support system providing two-way communication between an isolated client and a medical control center, 24 hours a day, 7 days a week.

- Home Delivered Meals (HDM) - meals, delivered to a client's home, each of which meets 33 1/3 % of the Recommended Daily Allowance (RDA) and otherwise complies with the American Dietary Association's Dietary Guidelines for Americans.

- Home Delivered Services (HDS) - Basic medical services provided under medical supervision to individuals who can be cared for at home. Includes care provided by a licensed health professional subsequent to diagnosis of a physical condition; monitoring of treatment plans and nursing and rehabilitation care such as physical, speech/hearing and occupational therapy and medical social services.

- Personal Support Services (PSS)/Extended Personal Support (PSSX) - Those tasks designed for clients who need assistance with activities of daily living such as: specific errands which enhance the client's being, light housekeeping, and/or basic personal care needs and basic home maintenance, as well as to relieve the person(s) normally providing care/oversight. PSS is not to exceed 11 units per visit. PSSX has a minimum of 12 units per visit.

- Skilled Nursing Services (SNS) – Nursing services provided to meet the medical needs of clients when a home health agency is unable to provide the service. These services are performed by a registered nurse, or, in certain cases, a licensed practical nurse in accordance with the plan of care.

- Out-of-Home Respite - A non-skilled service that provides temporary relief to the

caregiver(s) responsible for performing or managing the care of a functionally impaired person. Respite care is provided in a waiver approved out-of-home respite care setting.

- Traditional Case Management (TCM) + Enhanced Case Management (ECM)- Case Management is a collaborative process which includes assessing, implementing, coordinating, monitoring, evaluating options and services required to meet individual needs and making referrals as needed. Traditional/Enhanced Case Management may consist of nurses, RN and LPN, currently licensed in Georgia and social services workers.

PROCEDURES

Providers contracted with the Department of Community Health provide Medicaid waivered services in specific geographical areas.

1804 - 1982 GEORGIA COMMUNITY CARE AND SERVICES FOR THE ELDERLY ACT

POLICY STATEMENT

The 1982 Georgia Community Care and Services for the Elderly Act established the Traditional/ Enhanced EDWP in Georgia and assigns to the Department of Community Health primary responsibility for program policy development and administration. The Department gives high priority to coordination of various entities working together to provide quality, consumer-focused services.

POLICY BASICS

The legislative intent of the Community Care and Services for the Elderly Act is to:

- Assist functionally impaired elderly in living dignified and reasonably independent lives in their own homes or with their families
- Establish a continuum of care for such elderly in the least restrictive environment
- Maximize use of existing community social and health services to prevent unnecessary placement of individuals in long-term care facilities
- Develop innovative approaches to program coordination, staff training and service delivery that impact on cost avoidance, cost effectiveness, and program efficiency.

Other major features of the Act:

- Coordination of community based services
- Provision of a minimum of six services with four required services in each planning and service area (PSA). The four required services are listed below:
    - Case Management
    - Assessment of functional impairment and needed community services (Case Management

- Homemaker (Personal Support Services)
- Home Health Care Services (Home Delivered Services).

Additional features of the Act include the following:

- Mandatory assessment for individuals seeking nursing facility care funded by Medicaid
- Screening of participants for the program by a lead agency/AAA in each geographic service area.
- Assignment of administrative responsibility to DCH
- Use of a sliding-fee scale.

The 1982 act embraces four major concepts described in Chart 1804.1:

CONCEPT	FUNCTION
Continuum of care	Establishes that services for functionally impaired individuals must be coordinated to provide a series or range of services.
Least restrictive environment	Implies that functionally impaired individuals have the right to maintain dignity and independence by receiving needed services at home or in a community setting.
Cost effectiveness	Holds that some services can be provided more economically to individuals at home than can be provided to them in institutions.
Client self-determination	Means an individual may choose whether to enter an institution or remain at home. The right to choose promotes client independence and choice.

PROCEDURES

The 1982 Act requires for the establishment of a community care unit within the Department of Community Health to perform the following:

- Designate specific, geographic service areas to ensure efficient delivery of community-based services
- Contract with a lead agency (AAA) in each geographic area to coordinate services within the region

1805 – ADMINISTRATIVE ORGANIZATION

POLICY STATEMENT

The Traditional/ Enhanced EDWP Waiver Services Program in coordination with the Division of Medical Assistance (DMA) of the Department of Community Health (DCH) contracts with Area Agencies on Aging (AAA)/ Case Management agencies to administer the EDWP locally.

POLICY BASICS

The Department of Community Health designates the AAA sites to serve as lead agency for the Traditional/ Enhanced EDWP in each planning and service area.

PROCEDURES

The AAA is the gateway or community focal point through which aging programs are planned and coordinated.

Implementation of the Traditional/ Enhanced EDWP depends on coordination and communication of:

- State DFCS and county DFCS eligibility caseworkers and Division of Aging Adult Protective Services caseworkers
- Department of Behavioral Health and Developmental Disabilities (DBHDD), the Regional Boards, and regional/local treatment facilities
- Division of Healthcare Facilities Regulations, DCH
- Physicians
- Traditional/Enhanced EDWP Case Management
- Service providers.

1806 – DEPARTMENT OF HUMAN SERVICES

POLICY STATEMENT

The Department of Human Services (DHS) delivers a wide range of human services designed to promote self-sufficiency, safety and well-being for all Georgians.

POLICY BASICS

DHS was created by the Georgia General Assembly in the Governmental Reorganization Act of 1972. A second reorganization occurred in 2009 and the Agency name was changed to the Department of Human Services. The agency is currently comprised of the following divisions:

- Division of Aging Services
- Division of Family and Children Services
- Division of Child Support Services

These divisions are supported by 10 administrative offices, which include:

- Inspector General
- General Counsel
- Human Resource Management and Development
- Legislative Affairs and Communications
- Facilities and Support Services
- Information Technology
- Budget Administration
- Financial Services
- Procurement Contracts and Vendor Management
- Strategic Planning and Initiatives

The DHS Commissioner is appointed by and accountable to the State Board of Human Services. This nine (9) member board is appointed by the Governor to provide general oversight of the agency's activities by establishing policy, approving agency goals and objectives and other appropriate activities.

1807 – DEPARTMENT OF COMMUNITY HEALTH, EDWP WAIVERED SERVICES PROGRAM

POLICY STATEMENT

The Elderly and Disabled Waiver (EDWP), Department of Community Health, DCH, plans and oversees administration of the EDWP-Traditional/Enhanced services.

POLICY BASICS

Within the Department of Community Health, the Traditional/ Enhanced Community Care/ E D W P W a i v e r e d Services Program section serves as the Traditional/ Enhanced Community Care / EDWP Unit required by the 1982 Community Care and Services for the Elderly Act.

PROCEDURES

Major responsibilities of the Traditional/ Enhanced Community Care Services Program/EDWP Waivered Services Section include the following:

- Developing policies and procedures necessary for planning and oversight of program implementation

- Developing uniform client assessment criteria

- Developing definitions and standards for services
- Allocating service benefits and Case Management funding to each planning and service area

- Monitoring expenditures in all areas of the state to assure that services are delivered within budget
- Developing technical assistance and training packages for area agency staff, Case Management, and local service provider staff

- Promoting involvement of public and private agencies

- Developing Quality Management Strategies

1808 – DEPARTMENT OF BEHAVIORAL HEALTH, DEVELOPMENTAL DISABILITIES

POLICY STATEMENT

The Department of Behavioral Health and Developmental Disabilities (DBHDD) provides treatment and support services to people with mental illness and addictive diseases, and support to people with mental retardation and related developmental disabilities.

POLICY BASICS

The Georgia DBHDD serves people of all ages, including individuals with forensic issues, with the most severe, and those most likely to be long term conditions. Georgia's DBHDD regional offices are the contact points for people needing mental health services. The regional offices are responsible for planning, coordination, contracting for services and evaluating all publicly supported hospital and community programs.

Services are provided statewide through contracts with twenty-five (25) community service boards, boards of health and various private providers, and through state-operated regional hospitals.

PROCEDURES

Case Management refer EDWP clients to the regional offices, if applicable. These regional offices assure local coordination of mental health services and other, appropriate community-based mental health, developmental disabilities services.

1809 – DIVISION OF FAMILY AND CHILDREN SERVICES

POLICY STATEMENT

The Division of Family and Children Services (DFCS) provides Medicaid eligibility determination for EDWP clients not eligible for SSI.

POLICY BASICS

DCH, the agency responsible for funding the Traditional/ Enhanced EDWP, contracts with DFCS to provide Medicaid eligibility determinations for clients who do not receive Supplemental Security Income (SSI). SSI recipients usually receive SSI Medicaid.

DFCS determines eligibility for Food Stamps, Child Protective Services, Temporary Assistance to Needy Families, and various community based programs.

PROCEDURES

DFCS Medicaid eligibility specialists are responsible for these activities:

- Determining Medicaid eligibility locally, through the DFCS office located in the county of a client's residence
- Determining client's cost share, if MAO/PMAO
- Communicating eligibility and cost share information with Case Management.

1810 – DEPARTMENT OF COMMUNITY HEALTH

POLICY STATEMENT

The Department of Community Health (DCH) administers Medicaid funds and programs through the Division of Medical Assistance (DMA) and DCH's fiscal agent.

POLICY BASICS

DMA coordinates with the Traditional/ Enhanced Community Care Services Program/EDWP and performs the following activities:

- Establishes the level of care criteria for nursing facility placement.
- Applies to Centers for Medicare and Medicaid (CMS) for the 1915(c) Home and Community-Based Services Waiver Program which funds the Elderly and Disabled Waiver, Traditional and Enhanced.
- Assures adherence to all federal regulations governing the 1915(c) Home and

Community-Based Services Waiver Program.

- Develops policies and procedures necessary for program implementation and monitoring.

PROCEDURES (MEDICAID DIVISION)

The DMA of DCH is responsible for the following activities:

- Enrolls, re-enrolls, contracts with providers and recoups Medicaid funds and terminates providers when necessary
- Develops policies and procedures for EDWP providers
- Establishes and approves reimbursement rates paid to providers
- Reimburses Medicaid service providers
- Assists providers with billing problems
- Conducts utilization review (UR) of Traditional/ Enhanced EDWP and SOURCE providers to assure medical necessity for continued care and effectiveness of care is being rendered.

DCH contracts with a fiscal agent to pay Medicaid providers including those who provide Traditional/ Enhanced EDWP service(s) and to operate the Provider Enrollment Unit. The fiscal agent trains Medicaid providers in the billing process and reimburses them for authorized services. The fiscal agent also operates the Billing Inquiry Unit to assist Medicaid providers with questions related to billing and medical eligibility.

PROCEDURES (PROVIDER ENROLLMENT UNIT)

The fiscal agent's Provider Enrollment Unit distributes information (manuals and applications) about enrollment requirements to interested, prospective Medicaid providers. The phone number of the Enrollment Unit is (800) 766-4456 or (404) 298-1228 and the website: www.mmis.georgia.gov\portal.

After a prospective provider successfully completes the application requirements, the Department of Community Services reviews and recommends the prospective provider to the Division of Medical Assistance, which approves the issuance of a Medicaid provider number by the fiscal agent.

PROCEDURES (HFR DIVISION)

Of the many agencies and facilities licensed by the Health Care Facilities Regulation Division, HFR is responsible for licensing and regulating Private Home Care providers and Personal Care Homes in Georgia which are included in the services offered by the Traditional/Enhanced EDWP.

1811 – SERVICES PROVIDERS

POLICY STATEMENT

Service providers furnish direct services to Traditional/ Enhanced EDWP clients.

POLICY BASICS

Service providers include:

- Medicaid (Title XIX) waivered service providers
- Medicare (Title XVIII) service providers
- Older Americans Act (Title III) providers
- Social Services Block Grant (SSBG) providers
- Community Services Block Grant (CSBG) providers
- Other community-based or voluntary service providers.

PROCEDURES

DMA contracts with providers to furnish Traditional/ Enhanced EDWP services. Providers are responsible for the following activities:

- Developing a Provider Care Plan for every client served
- Supplying services indicated on the Provider Care Plan
- Giving Case Management information affecting the Provider Care Plan
- Communicating with Case Management utilizing the EDWP Notification Form
- Supervising care delivery as specified in provider service manuals
- Obtaining approval from the Case Management before changing duration, frequency, or scope of EDWP services and following up with a completed EDWP Notification Form
- Communicating with Case Management regarding failure of a MAO /or potential MAO client to pay required cost share
- Assisting Traditional/ Enhanced EDWP clients in obtaining a DMA-6 Form when they plan to enter a nursing facility
- Attending Network Meetings held by local Area Agencies on Aging
- Sending a completed Provider Inquiry Form (DMA-520) to DMA to resolve billing

problems (Appendix C-3 of Billing Manual)

- Adhering to Traditional/ Enhanced EDWP and DMA rules and regulations.

Activities *not appropriate* for Traditional/Enhanced EDWP providers include:

- Soliciting clients from other providers
- Soliciting the delivery of all services with one provider when a client receives two or more services
- Soliciting contract home(s) from another ALS-F provider
- Refusing to provide the full range of activities required for a particular Traditional/ Enhanced EDWP service type.

1812 – PHYSICIANS

POLICY STATEMENT

Traditional/ Enhanced EDWP services directly relate to each client's medical condition and resulting physical impairments. The client's physician is a participant in the Case Management process.

POLICY BASICS

The client's physician is familiar with the client's specific health service needs, provides required medical information and consultation to the Case Management.

PROCEDURES

To assist the Case Management in determining the level of care and the needed services, the physician provides the following:

- Consultation if questions regarding a client's medical status exist
- Additional medical information and completion of forms for assessment and reassessment
- Signature on the Traditional/ Enhanced EDWP Services Program Level of Care and Placement Instrument, to approve the Comprehensive Care Plan
- Certification that client condition can or cannot be managed by Traditional/ Enhanced EDWP and/or Home Health services.

NOTE: Members must be seen by their PCP annually, either in the office of the PCP or via Telehealth with the SNS provider RN performing the call.

1813 – AREA AGENCIES ON AGING

POLICY STATEMENT

The Area Agency on Aging (AAA) is the Lead Agency, the gateway or focal point at the community level. Case Management is provided directly through stand-alone agencies.

POLICY BASICS

Area Agencies on Aging were created by the 1973 amendments to the Older Americans Act in Title III, Section 304(b), which authorized State Units on Aging to divide the state into planning and service areas and to designate Area Agencies on Aging. The AAA's primary role is to develop a comprehensive service delivery system responsive to persons 60+ and focusing on the provision of community-based and in-home services with appropriate linkages to institutional care.

The AAAs prepare Area Plans which identify and prioritize needs of the elderly and specify which services will be provided to meet those needs. The AAAs submit these plans to the Department of Community Health for approval.

AAAs in Georgia are either public agencies located within quasi-governmental planning agencies called Regional Development Commissions (RDCs) or private non-profit agencies with a free-standing board of directors.

PROCEDURES

The AAA is responsible for the following activities:

- Assures DCH administrative policies and procedures regarding conflicts of interest are followed
- Educates the community about available programs and services
- Assures that the EDWP is accessible to the community
- Promotes EDWP for eligible individuals
- Promotes the development of a comprehensive service delivery system with a continuum of care
- Coordinates EDWP services for its PSA
- Processes referrals to the chosen Case Management agencies be served in the PSA
- Reviews and comments on applications from potential EDWP providers in the PSA
- Requests written approval from the Department of Community Health for any variances in policies and procedures; for example, before employing or contracting with an individual who does not meet Case Management qualifications

- Makes site visits, as appropriate, to EDWP service providers.

The AAA is responsible for following EDWP activities that are not reimbursed by Medicaid, or allowable under Case Management administrative functions:

- Assists providers with billing problems unless it concerns Service Authorization Forms (SAFs)
- Develops Area Plan
- Provides public education:
    a) Speaking engagements
    b) Health fairs
- Conducts advocacy activities
- Provides enrollment information for potential EDWP providers
- Reviews potential provider enrollment applications
- Negotiates provider working agreements
- Provides representation on boards and councils in support of EDWP if not done so by the Case Management agency
- Provides Information and Referral, including Nationwide Eldercare Locator Hotline
- Develops resources

Services provided by the ADRC/AAA- https://aging.georgia.gov/locations

- **Adult Day Care** – Provides supportive care in a community group facility during the day with professional trained caregivers
- **Alzheimer Training -** Provides education and training to professionals and caregivers. Trainings include: Dealing with Dementia, and Powerful Tools for Caregivers.
- **Assistive Technology** – Information, demonstrations, assessments and limited equipment purchases
- **Care Consultation -** telephone coaching service which empowers people to understand options, manage care, and make decisions more effectively
- **Case Management -** assessing needs, developing care plans, authorizing and coordinating services among providers, and providing follow-up and reassessment, as required
- **Elderly and Disabled waiver Program (EDWP) - Title XIX –** Long-Term Care Waiver to prevent premature institutionalization
- **Congregate Meals** – A meal provided in a group setting for the purposes of prevention and reduction in social isolation.

- **GeorgiaCare**s- Provides information on Medicare/Medicaid health insurance and supplemental policies.
- **Home Delivered Meals** – nutritious meals provided to qualified individuals in their residence
- **Homemaker Services** – provides in-home assistance with light housekeeping and meal preparation
- **Legal Assistance** - Provides legal assistance on rights, benefits, and entitlements to older adults
- **Nursing Home Transition Services** – Provides support to eligible individuals living in a nursing facility or an intermediate care facility, who wish to move into their own home or appropriate group setting
- **Personal Care Services** – Provides assistance with bathing and personal care needs
- **Respite Care** – Providing supportive assistance to the caregiver through the provision of a temporary break in caring for the care receiver
- **Senior Community Service Employment Program (SCSEP)** - Provides training and part-time subsidized employment and assistance to locate unsubsidized employment for low income persons age 55 years and older
- **Transportation** - Provides access to and from nutrition centers and other community resources

1814 –PROGRAMMATIC REPORT POLICY STATEMENT

Each AAA and Case Management agency is required to query, confirm and submit a separate monthly programmatic report to the Department of Community Health by the fifteenth of each month for the previous month's work. Failure to submit timely could lead to the suspension of referrals. See Part II Chapters 600-1000 Policies and Procedures for Elderly and Disabled Waiver Program (EDWP) CCSP and Source General Services Manual 602.1 B.

POLICY BASICS

The Traditional/ Enhanced EDWP Programmatic Report provides programmatic information regarding AAA and Case Management activities.

The Department of Community Health uses report information to:

- Complete federal and state reports
- Determine if program objectives are being met
- Calculate and track whether programmatic budget limitations are being observed
- Provide information to legislators, advocates and others
- Determine statewide how many clients may be added to the program.

The Traditional/ Enhanced EDWP Report provides information regarding:

- Nursing home admission
- Disposition of completed initial/annual assessments that are recommended/not recommended for Traditional/Enhanced EDWP
- Waitlist activities
- Summary of monthly supervisory reviews

The Department uses report information to determine:

- Why clients are placed in nursing homes with or without hospitalization
- Why clients are not recommended for Traditional/ Enhanced EDWP under Disposition of Completed Initial Assessments "other"
- Why clients were terminated under the Number of Clients Terminated by Category "other"
- Number of persons on the waiting list receiving non- EDWP services pending Traditional/ Enhanced EDWP admission and the average time clients were on the waiting list prior to Traditional/ Enhanced EDWP admission.

PROCEDURES

The AAA is responsible for accuracy and approving the content of these reports. The AAA collects screening and waitlist information from the electronic data system monthly.

1815 – NETWORK MEETINGS

POLICY STATEMENT

The Department of Community Health conducts quarterly meetings for participants involved in Traditional/ Enhanced EDWP and SOURCE service delivery.

POLICY BASICS

The following participants attend network meetings:

- Appropriate AAA staff
- Case Management and/or supervisors
- Service providers
- DFCS eligibility caseworkers

- APS caseworkers
- Waiver Program aging coordinators
- Hospital discharge planners
- DCH Traditional/Enhanced waiver specialist
- Other interested persons.

PROCEDURES

Beginning in October 2019, SFY 2020, meetings will be transitioned to a Web-X format, hosted by the Department of Community Health. Providers enrolled in CCSP and SOURCE are required to attend two web x type AAA Network Meetings during the state fiscal year (July 1-June 30). To allow for planning and agenda specifics, DCH will send agenda/topic/speaker requests to all AAA staff lead participants with enough advance notice that the AAA lead participants have time to add items prior to the collaborative meeting.

Network meetings are held to:

- Identify problems and their resolution
- Present unique or problematic cases
- Clarify policies and procedures
- Report on status of budgets, waiting list, and allocations
- Discuss issues of common concern.

The following information is disseminated by DCH in collaboration with all 12 AAAs at network meetings:

- Agenda
- Name and contact information of Traditional/Enhanced EDWP staff and areas served
- Number of clients by county on twelve-month basis
- Monthly service authorization summary by service (electronic data system Reports)
- The PSA Programmatic Report, or a summary program report
- Provider listing by service and counties served (introduce new providers, services provided and counties served).

1816 – ADVOCACY

POLICY STATEMENT

The AAA assures that the service delivery system is responsive to the needs of the target population.

POLICY BASICS

AAAs have the primary role at the community level in advocating for the elderly.

The AAA determines what advocacy initiatives are required to assist in meeting the needs of EDWP clients.

AAAs have the primary role at the community level in advocating for the elderly.

PROCEDURES

The Case Management advocates for a client by completing the following activities:

- Implementing clients' Comprehensive Care Plans
- Assuring that clients receive the most appropriate services
- Informing AAA staff of gaps in service, services in greatest demand, areas where informal support groups are needed, and service areas which need volunteers
- Communicating to the AAA staff any problems that may surface in regard to client care and wellbeing.

1819 – COMMUNITY TRANSITIONS –

Formerly MONEY FOLLOWS THE PERSON GRANT

SUMMARY STATEMENT

In May 2007, the Centers of Medicare and Medicaid Services (CMS) awarded Georgia the Money Follows the Person (MFP) Rebalancing Demonstration grant established by the Deficit Reduction Act of 2005. Community Transitions (CT), formerly knowns as Money Follows the Person, is a multiple year grant awarded to the Department of Community Health (DCH) which has overall responsibility for policy and operational issues. (C T) / Money Follows the Person provides transitional services to Medicaid funded, institutionalized individuals who choose to live at home in their community rather than remain in a nursing home. Individuals transitioning from the nursing home are generally eligible for home and community based services provided thru one of the 1915-C Georgia Medicaid Home and Community Based Services waivers. The Traditional/ Enhanced EDWP is one program to which an individual eligible for (C T) / MFP may be referred. (C T) / MFP may provide necessary transitional services to (C T) / MFP eligible individuals for a maximum of three hundred sixty-five days from the date the individual is discharged from the nursing home.

BASIC CONSIDERATIONS

CT/MFP clients referred for the Traditional/ Enhanced EDWP are not subject to wait list during times when no admission restrictions are in place. They are referred after the MDS-Q Options Counselor provides the screening in the nursing home and refers to the CT/MFP Transition Coordinator who then refers the client to Traditional/ Enhanced EDWP Case Management Agency via the ADRC for face to face nursing assessment. A telephone screening does not occur.

Case Management works closely with the CT/MFP Transitional Coordinator (TC) as a part of the transition team to collaborate about the individualized client comprehensive care plan. Traditional/ Enhanced EDWP CM is required to attend at least one Individual Transition Plan (ITP) meeting which discusses the Traditional/ Enhanced EDWP plan of care, services and service delivery plan. CM may attend other transition meetings as available. Participation in ITP meetings may be accomplished by telephone conferencing in lieu of face to face attendance.

Communication between the TC and the CM is critical to planning and coordination to achieve successful client transition to the community

PROCEDURES

Potential CT/MFP client is referred for Traditional/ Enhanced EDWP Intake and Screening:

- ADRC Telephone Screener determines CT/MFP client is appropriate and eligible for Traditional/Enhanced EDWP
- ADRC refers client for nursing assessment completed by Nurse/ CM in the nursing home where the client resides
- Nurse/ CM completes assessment documents and communicates his/her determination to the CT/MFP TC
- CM attends ITP meeting to discuss Traditional/ Enhanced EDWP services
- Assessment documents are forwarded to Alliant Health Solutions (AHS) for validation of level of care and then to the client's physician or the agency's Medical Director for approval of care plan and health and safety recommendation.
- RN certifies LOC when received from the physician or the agency's Medical Director and forwards a copy of the Level of Care and Placement Instrument and the Traditional/ Enhanced EDWP Communicator to the TC.

NOTE: When the CT/MFP client resides in one PSA but will discharge/transition to a different PSA, the ADRC/ CM agency in the PSA where the client resides will complete the steps listed above. The CT/MFP TC in the assessing area will provide communication and notification to the receiving CM agency regarding ITP meetings and other transition information.

NOTE: In situations where the approved LOC and PA from Alliant Health Solutions (AHS) remain in place and the client does not transition from the facility in a timely manner, do not perform a new assessment. The nurse needs to complete a face-to-face review of the client's needs (if in NH for over 60 days after RN LOC approval) and process the file to the new agencies for initial brokering along with an updated care plan.

NOTE: CT/MFP client transitions which have not occurred within one calendar year of the final ITP meeting will be terminated from the Traditional/ Enhanced EDWP due to no services provided. The CM will contact the TC prior to the discharge to ensure that the transition has not been scheduled. A copy of the discharge notices will be sent to the TC.

Once the client is discharged from the nursing home to the community, Case Management shall provide monthly contact (telephonically or face-to-face) as 30 and 90- day reviews. Telephonic monthly contact while client is in the nursing home can be documented in formal notes, no monthly assessment is required. The first home visit will be the thirty (30) day care plan review.

If the CT/MFP client desires to transition from the nursing facility to a non- CT/MFP living environment (over 4 beds) ALS vs CT/MFP allowed maximum four bed ALS, that client must be counseled on the risk this choice may pose for the opportunity to qualify for either CT/MFP or Traditional/ Enhanced EDWP. The client will lose the ability to be classified as CT/MFP and will face termination from or delayed entry into the client choice of Traditional/ Enhanced EDWP site if the client's current DON R score is below what the highest AAA wait list level score is for applicable clients ready for transfer from the AAA for assessment. A referral to the ADRC for screening and placement on that area wait list follows CT/MFP termination at client request.

Once the client has confirmed that he/she has affirmatively chosen to end the CT/MFP status, evaluate the DON R score from the most recent assessment, if performed within the last 270 days, and determine if scores at the AAA level would allow client to remain on Traditional/ Enhanced EDWP in a traditional slot. If client score is below what is at the AAA wait list level, client is appropriately notified that he or she has been removed from CT/MFP, terminated from Traditional/ Enhanced EDWP and referred back to the ADRC for screening as a traditional client to be added to the Traditional/ Enhanced EDWP waiting list.

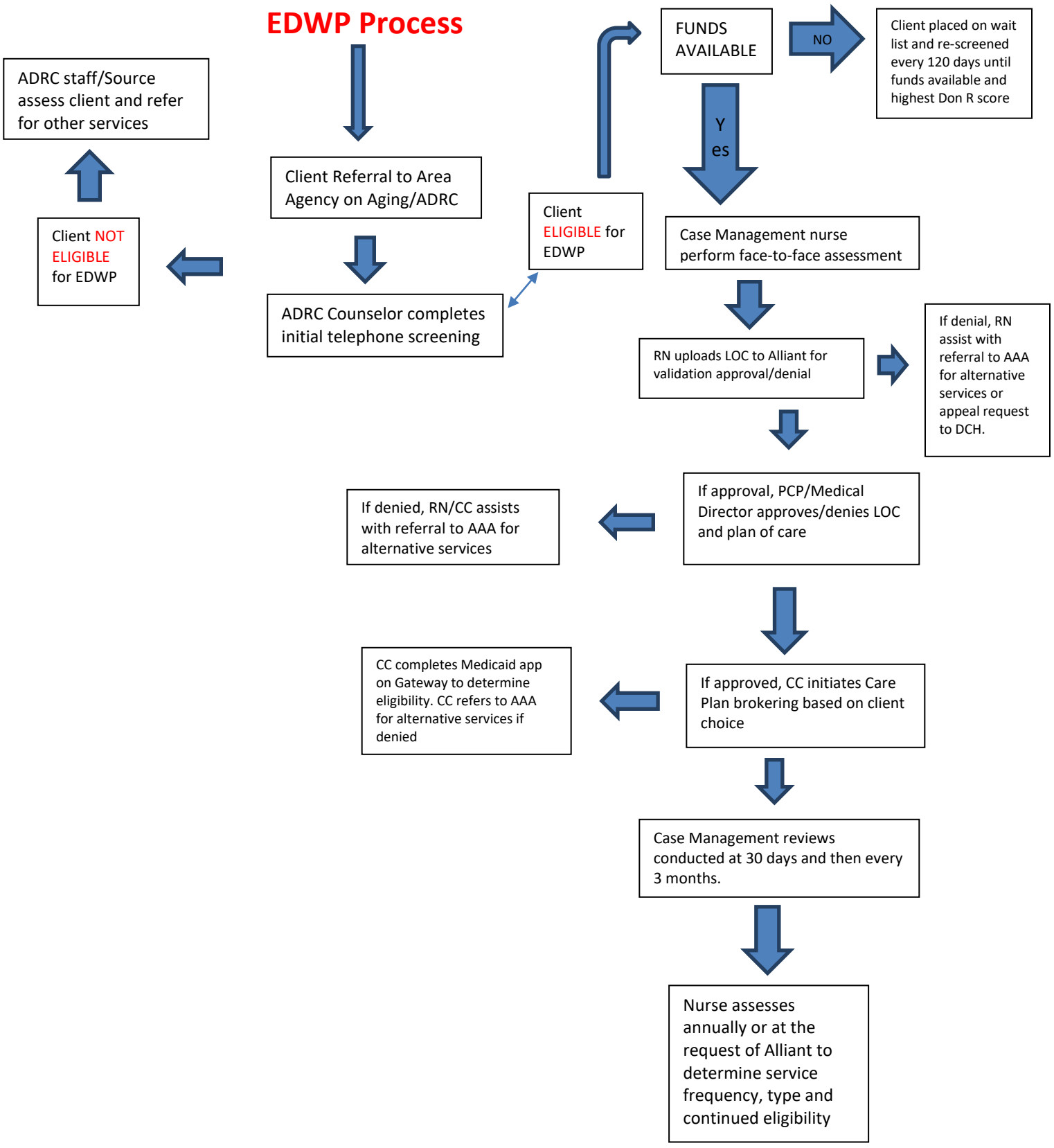
NOTE: If MDS is greater than 270 days old at the time that the client desires to leave CT/MFP status, perform new assessment to determine current DON-R level. Client's new DON-R score will be evaluated for eligibility to remain an active participant in the waiver in a traditional slot.

NOTE: The Transition Coordinator (TC) obtains the DMA 59 from the nursing home. The form is attached to the Traditional/ Enhanced EDWP CCC/ communicator along with the level of care page for Traditional/ Enhanced EDWP / Level of Care and Placement Instrument provided to the TC by the Case Management from Traditional/ Enhanced EDWP. The Transition Coordinator obtains the required documents for the nursing home to the EDWP Medicaid changeover that is uploaded on Framework. DCH staff retrieves the documents from the CT/MFP section of Framework once uploaded and sends them to staff at the Long Term Care (LTC) Unit on floor 19, 2 MLK Jr. Dr. SE, Twin Towers East, Medical Assistance Plans, Atlanta, Georgia, so they can convert the member's Medicaid case from nursing home to Traditional/ Enhanced EDWP Medicaid Elderly and Disabled Waiver. The transition from NH Medicaid to Traditional/ Enhanced EDWP Medicaid is to be uninterrupted, for a continued Medicaid determination. There is not to be a new application requirement for this change.

NOTE: Potential Medicaid CT/MFP client paperwork for the Department of Family and Children Services application for Medicaid will have the Traditional/ Enhanced EDWP Communicator (CCC) Section 1 Case Management begin date and service slot date equal the Level of Care and Placement Instrument Nurse visit date. Traditional/ Enhanced EDWP case management providers will bill GAMMIS for all Traditional/ Enhanced EDWP case management services under the $175.00/$192.27 fee for service rate, beginning with the month of the nurse's initial in-home assessment of the member for admission to Traditional/ Enhanced EDWP. If the client is in a nursing home/rehab facility, Case Management billing begins the day after

discharge from the facility.

1820 – Traditional/Enhanced EDWP PROCESS



Traditional/ Enhanced EDWP Case Management

1821 – ELIGIBILITY CRITERIA

POLICY STATEMENT

An applicant/client must meet all the Traditional/ Enhanced EDWP eligibility criteria to participate in the program.

POLICY BASICS

Eligibility includes both functional and financial eligibility criteria for those 21 years of age and older. RN Case Management determine functional eligibility for required nursing care. The Department of Community Health (DCH) /DMA establishes eligibility criteria for Medicaid and contracts with DFCS to determine financial eligibility. Medicaid eligible members under the age of twenty-one (21) will be referred to Medicaid's GAPP (Georgia Pediatric Program) to be screened for medically necessary skilled nursing and or medically necessary personal care support through Medicaid's State Plan services. Any service request for those under 21 that is not covered in the State Plan under GAPP or Autism Spectrum Disorder Services can be referred for screening and eligibility determination of the requested service. As the Department moves to evaluate children on the waiver and compliance with federal mandates, continuity of care will be the first concern.

The eligibility criteria for Traditional/ Enhanced EDWP include the following:

- Functional impairment caused by physical limitations

NOTE: Alzheimer's and other types of dementia are physical conditions.

- Unmet need for care
- Approval of care plan by applicant/client's physician or the agency's Medical Director
- Services fall within the average annual cost of Medicaid reimbursed care provided in a nursing facility
- Approval of an intermediate LOC certification for nursing home placement by a Traditional/ Enhanced EDWP RN
- Validation of an intermediate LOC for nursing home placement by Alliant Health Solutions.
- Medicaid eligible or potentially eligible based on age (65 or older), or totally disabled.

- Client chooses community-based, rather than institutional services
- Health and safety needs can be met by Traditional/ Enhanced EDWP
- Participation in one waiver program at a time
- Medicare home health or hospice services does not meet client's needs
- Home Delivered Meals, Assistive Technology and Case Management combined is not the only service need
- The home environment is free of illegal behavior and threats of bodily harm to other persons.

NOTE: A client is not required to be homebound to receive Traditional/ Enhanced EDWP services.

Enhanced Case Management

Under the direction of a Medical Director/Physician.

- Can utilize a Nurse Practitioner/Physician Assistant for case conference meetings and signing the applicable papers/forms.

NOTE: Nurse Practitioner or PA have to be supervised by a physician and have language in the contract with the Case Management agency that addresses their supervision by a Physician under established protocol. The Nurse Practitioner/Physician Assistant must have access to the MD by GA license.

- Periodic meetings with the Medical Director on each ECM member.
  - The medical director can be scheduled for case conference meetings on a weekly, bi-weekly or monthly basis as needed. Meetings via phone/computer must be with the use of a hipaa compliant system.

    NOTE: The Medical Director can sign all Level of Care and Placement Instruments and revised orders for ECM members at these conferences.

- Medical Director periodic tasks –
  - Review of the Nursing Supervisory Visit form/Appendix DD
  - Review (applicable) either the ECM HAR or the *Defining ECM* Conference forms

- Case Management tasks-
  - Performance of the EDWP *Enhanced Provider Contact* assessment within the electronic data system every 6 months
  - Submission of the *ECM DM Physician letter* initially and every six months to the primary care physician
  - Sign initially and annually the ECM HAR report or the *Defining ECM Conference* form after performance of the MDS (or applicable Modified, noting condition changes). Member may not meet ECM at time of MDS assessment but later has a condition change and would meet eligibility based on the completed '*defining ECM'* form and results from the completed modified assessment).
  - Review, sign and return of the Nursing Supervisory Visit form/Appendix DD

Nursing Supervisory Visit form/Appendix DD

- Completed by the provider RN of Skilled Nursing in the home at care plan updates and/or other service provider agencies (ALS, ADH, PSS/X) at each RN supervisory visit or upon request by the case management agency.
    - The service provider will complete the appendix DD (ADH, ALS, SNS or PSS/X RN) with submission to the ECM Case Management. In leu of the appendix DD, supervisory notes from that service's RN is appropriate if the information contains the contents of the appendix DD. *Those on SFC alone can utilize the documentation from the health coach and RN as supervisory requirements are not a part of this service. Cd pss has no appendix DD requirement.*
- Completed by the provider RN of Skilled Nursing in the home at Case Management ordered, scheduled telehealth visits with the member's PCP (regardless of whether they're receiving traditional or enhanced case management)
- Reviewed, signed and returned by Case Management RN and Medical Director
- Completed at each of the provider **RN** supervisory visits
    - If supervisory is done by LPN, RN will do at her/his next supervisory visit.
- Skilled nursing visits can be authorized on the SAF in the electronic data system to meet the needs of each case. If authorizing primarily LPN visits to cover the member's nursing needs, authorize at least one RN visit so the RN can bill for the supervisory visit if they render a nursing service visit during the same visit. Authorize RN visits more frequently as needed for assessment of the member and follow-up on the care plan.
        - Skilled nursing must be appropriate, with physician orders for care needed… ie medication monitoring The LPN can fill the med box on a weekly basis, but the RN should be authorized for periodic visits for supervision and follow-up on the member's compliance.
        - An RN visit can't be authorized just for completion of the Nursing Supervisory Visit form/Appendix DD at the supervisory visit.

PROCEDURES

Functional Assessment: Use the Determination of Need Functional Assessment-Revised (DON-R) to determine an applicant/client's level of impairment and unmet need for care for Traditional/ Enhanced EDWP.

- Level of Impairment assesses an applicant/client's ability to perform an activity.

- Unmet Need for Care determines an applicant/client's need for care for every identified level of impairment. Unmet need is not required for continued enrollment.

To be eligible for Traditional/ Enhanced EDWP, an applicant/client must obtain a level of impairment score of at least 15 and have an unmet need for care.

Physician Approval: Request the applicant/client's physician or the agency's Medical Director to certify the following:

- Applicant/client's condition can/cannot be managed by Traditional/ Enhanced EDWP service

- Applicant/client requires/does not require the intermediate level of care provided by a nursing facility

- The care plan completed by the Case Management addresses the applicant/client's needs.

NOTE: Members must be seen by their PCP annually, either in the office of the PCP or via Telehealth with the SNS provider RN performing the call.

Cost Limit Guidelines: Assure that an applicant/client's care in the Traditional/ Enhanced EDWP program does not exceed the cost limits established by DCH by performing the following:

- Use only waivered services reimbursed by Medicaid to calculate the cost of an applicant/client's service.

EXAMPLE: The applicant/client receives waivered services from Medicare and Medicaid. Disregard Medicare service costs and Medicaid Home Health if the applicant/client has received less than 50 visits in the calendar year.

- Prepare a care plan which addresses the applicant/client's needs.

- Evaluate whether community-based services are more cost effective than institutional placement.

Level of Care: Use the criteria in the Intermediate Level of Care Indicators chart to determine an applicant/client's degree of disability. An applicant/client must have functional impairment equivalent to the nursing home Intermediate Level of Care.

An approved current Level of Care by the Traditional/ Enhanced EDWP RN is required for an applicant/client to participate in the EDWP, validation of the Level of Care performed by Alliant Health Solutions (AHS).

Medicaid Eligibility: Perform the following activities to determine an applicant's eligibility or potential eligibility for Medicaid:

- Ask if the applicant receives Medicaid
- If the applicant is not Medicaid eligible, assess the applicant's income and resource eligibility for Traditional/Enhanced EDWP Medicaid or SSI.

Client Choice: Present to the client a choice of the Traditional/ Enhanced EDWP or institutional placement. Document the applicant's choice on Comprehensive Care Plan (CCP). If the applicant chooses to participate in institutional care instead of EDWP, do not continue the assessment for the initial care plan.

Health and Safety: Determine the health risks and unmet needs if the applicant were admitted to EDWP.

NOTE: If needed, review the Traditional/ Enhanced EDWP service manuals and HFR regulations to determine if Traditional/ Enhanced EDWP can meet the client's needs.

Waiver Participation: Explain that a client may receive services in only one waiver program at a time.

Medicare Home Health or Medicare/Medicaid Hospice: Determine if the client has a need not met by Medicare home health or Medicare/Medicaid hospice care.

If an individual already receiving Traditional/ Enhanced EDWP services is admitted to hospice care, the client may continue to receive Traditional/ Enhanced EDWP, if needed. Clients receiving Traditional/Enhanced EDWP and hospice may receive PSSX, HDM, ADH, ERS, or ALS.

*Collaboration between the Case Management and the Hospice agency is required regarding duplication of services, client needs and service updates and general policy compliance.

The member's EDWP team and the hospice program's case manager and member must communicate, establish, and agree upon a coordinated plan of care for both providers that prevents duplication of services. Distinct Case management services must be agreed upon to be given by each agency. **Information on these areas is documented at the beginning of the relationship and quarterly, both in the assessment and case note is recommended. More frequent communication should be documented if the need arises**]. Hospice must be a part of the discussion and coordination with hospice should be documented whenever the plan of care is modified, even if more often than quarterly.

While attempts to coordinate cannot be forced, attempts to coordinate care should be thoroughly documented. Attempted contacts in notes and assessments is evidence of good faith effort to comply with the coordination of care requirement, keeping fax cover sheets and fax confirmation print outs, log any phone calls or voicemails, and document any mailings and delivery confirmations. Similarly, any coordination-related changes to the plan of care should be documented clearly. For example, if a patient enters hospice and their Emergency Response Service is discontinued because of that hospice admission, the case manager may document to "suspend ERS effective April 1, 2023 – patient instructed to call the hospice on-call nurse line for emergencies." This shows that the case manager is actively incorporating hospice into their care planning, even though their attempts to contact hospice were not successful.

NOTE: Clients enrolled in the Consumer Directed Option for Personal Support Services (CDPSS) may receive Hospice Services but care must be provided at a minimum stay of 12 units per visit.

Home Delivered Meals: Refer client who needs only HDM to other resources.

Safe Home Environment: Determine if the applicant or others living in the home have inflicted or threatened bodily harm to another person within the past 30 days.

1822 – Traditional/ Enhanced EDWP MEDICAID ELIGIBILITY

POLICY STATEMENT

The Traditional/ Enhanced EDWP class of medical assistance provides Medicaid benefits to individuals receiving Traditional/ Enhanced EDWP waivered services. However, Traditional/ Enhanced EDWP clients may be eligible for Supplemental Security Income (SSI) or another class of medical assistance.

POLICY BASICS

To be eligible for the Traditional/ Enhanced EDWP Medicaid an individual must meet the following eligibility criteria:

- Be age 65 or older or totally disabled
- Be a U.S. citizen or a lawfully admitted alien
- Be a resident of Georgia (There is no time limit to establish residency, only the intention to live in Georgia.)
- Agree to assign all health insurance benefits to the Division of Medical Assistance
- Apply for and accept any other benefits which may help to pay for medical expenses
- Have income less than the Medicaid monthly income cap
- After applying all exclusions, have resources that do not exceed the limit for this class of assistance
- Receive a Medicaid-reimbursable, waivered service every calendar month under a Comprehensive Care Plan developed by a Case Management.

NOTE: For any month that DFCS is determining a client's eligibility for Traditional/ Enhanced EDWP Medicaid, a client must receive a waivered service. SSI Medicaid is not contingent on a client receiving a waivered service.

NOTE: Case Management alone is considered a waivered service. Client choice of limited care (Case Management alone) is allowed if chosen by client, while in Medicaid pending status.

- Meet the length of stay (LOS) requirement.

The LOS requirement for Traditional/ Enhanced EDWP Medicaid is 32 consecutive days, starting with the first day in Case Management or a combination of days in Traditional/ Enhanced EDWP

Traditional/ Enhanced EDWP Case Management

and other medical treatment facilities (MTF). All continuous institutional living arrangements, regardless of type, are counted to meet LOS requirements.

The DFCS Medicaid eligibility specialist will presume the client meets the length of stay requirement unless the Case Management sends a Traditional/ Enhanced EDWP Communicator (CCC) to advise the worker the client has left Traditional/Enhanced EDWP.

To maintain continuous eligibility for Traditional/ Enhanced EDWP Medicaid, a client must receive a waivered service each calendar month.

PROCEDURES

Follow the same functional assessment procedures for the MAO and potential MAO clients as for current SSI Medicaid clients.

A DFCS eligibility specialist determines the client's Traditional/ Enhanced EDWP Medicaid eligibility and exact cost share amount. Refer clients to DFCS for eligibility or cost share determination. Send the CCC and LOC to DFCS.

Potential Medicaid client paperwork for the Department of Family and Children Services application for Medicaid will have the Traditional/ Enhanced EDWP Communicator (CCC) Section 1 Case Management begin date and service slot date equal the Level of Care and Placement Instrument Nurse visit date.

NOTE: DFCS will also determine disability eligibility cases upon request from EDWP when clients have no disability determination from Social Security. The State Medicaid Eligibility Unit (SMEU) will issue a determination.

EXCEPTION: SSI recipients receive SSI Medicaid and are not required to apply for Medicaid at DFCS or cost share. The Social Security Administration determines SSI eligibility**.**

Monitor the progress of the Medicaid referral with client and DFCS.

NOTE: Case Management service and Home Delivered Meals are not subject to cost share collection. All other waivered services require payment of cost share if applicable and assigned by the Department of Family and Children Services.

Use Chart 1822.1 when screening applicants entering EDWP for Medicaid eligibility regardless of whether they are SSI, MAO, or PMAO:

Chart 1822.1 - EDWP MEDICAID ELIGIBILITY REQUIREMENTS

IF	THEN
Traditional/ Enhanced EDWP Case Management	

Applicant is a single individual applying for Traditional/Enhanced EDWP **NOTE:** The individual income limit for Traditional/Enhanced EDWP Medicaid is equal to three times the SSI level. The Traditional/ Enhanced EDWP Medicaid income limit changes in January each year when the SSI level increases.	• Applicant's income must be within the allowable income limit for Traditional/ Enhanced EDWP Medicaid. **NOTE:** An applicant may establish a Qualifying Income Trust to reduce income. • Countable assets must not exceed the Traditional/Enhanced EDWP Medicaid resource limit for an individual.
A couple is applying for Traditional/ Enhanced EDWP	• Couple's income must be within the allowable income limit for Traditional/ Enhanced EDWP Medicaid. • Countable assets must not exceed the Traditional/ Enhanced EDWP Medicaid resource limit for a couple.

Applicant has spouse not applying for Traditional/ Enhanced EDWP (Spousal Impoverishment)	• Applicant's income must be within the allowable income limit for Traditional/ Enhanced EDWP Medicaid. • Traditional/ Enhanced EDWP client and spouse's <u>combined</u> assets must not exceed the limit. The Medicaid applicant must transfer his or her assets, in excess of the individual limit, to the community spouse within one year from the month in which Traditional/ Enhanced EDWP Medicaid eligibility begins. **NOTE:** Applicant may divert income to community spouse not in Traditional/ Enhanced EDWP to reduce the cost share.
Applicant dies after Case Management has begun	Applicant is presumed to have met LOS requirements, provided all other eligibility requirements are met, including the receipt of a waivered service.

1823 – Traditional/ Enhanced CASE MANAGEMENT

SUMMARY STATEMENT

Case Management facilitates the process of screening, assessing, planning, arranging, coordinating, delivering and evaluating service delivery for all applicants/clients in the Traditional/ Enhanced EDWP. Unless otherwise indicated, a registered nurse, licensed practical nurse or social services worker may conduct these processes.

BASIC CONSIDERATIONS

Every Traditional/ Enhanced EDWP client enters the program through the Case Management process. The Case Management's primary responsibility is to the client. Case Management is either registered nurses, licensed practical nurses (LPN) or social services workers.

The registered nurse supervises the LPN. At a minimum, each agency will employ one RN to provide clinical supervision, assessment performance, level of care approval/denial review for Alliant Health Solutions (AHS) submission as well as testimonial representation at level of care appeal hearings.

Due to the complex nature of EDWP Case Management and the fragility of the population, only established businesses with a history of providing case management may enroll.

All applicant's companies must provide the following documentation of their experience and qualification to provide case management services:

(1) Proof of experience in case management for a minimum of twenty-four months prior to making application for enrollment. Case Management includes initial and annual assessment, care plan development and monitoring, working with other service providers, financial responsibility management etc.
(2) Proof of business management experience, managing 5 or more employees, in the health care field, for a minimum of twelve (12) consecutive months prior to making application for enrollment.
(3) Proof of assurance of conflict free case management. See below page 48.
(4) Proof of the ability to perform work in the current DCH electronic data system.
(5) Information regarding their anticipated use of a Medical Director in the Enhanced Case Management option, providing a written agreement with the person chosen for that position. Describe how the staff member will provide clinical oversight required by the program.
(6) An organizational chart for the agency that includes all related positions with clear lines of authority. Submit job descriptions for all positions as well as resumes, documenting the number of staff members in each position.
(7) Documentation of normal operating hours and days for the office. Describe how a 24-hour a day/seven days per week/365 days per year on-call system will be maintained. Describe how the timeliness to calls and response to problems will be documented and reviewed.
(8) Documentation on how a multitude of providers will be used in a client choice pattern for your agency.
(9) Documentation on how conflict of interest could occur and will be avoided with the Service

Provider Community.

(10) A description of how the program will provide quality assurance oversight, describing how members are receiving services ordered and that care plan risks are being monitored on a regular basis. A description of how the program will correct and monitor deficiencies found during QA is required as well.

(11) A description of who will be responsible for billing Medicaid for the Case Management fee and the process for oversight of billing.

(12) Documentation of maintenance of a satisfactory record of compliance with federal and state laws and regulations, and must not be currently or previously prohibited from participation in any other federal or state healthcare program or have been convicted or assessed fines or penalties for any health related crimes, misconduct, or have a history of multiple deficiencies cited by Utilization Review and/or deficiencies that endanger the health, safety, and welfare of the member.

(13) Documentation of a lack of deficiencies within the past 3 years from any licensing, funding, or regulatory entity associated with enrollment in any Medicaid services, or with the provision of any related business unless such deficiencies have been corrected to the satisfaction of the imposing entity.

(14) The Case management provider will include within its operational procedures a Language Access Plan that confirms that a medical interpreter service (including sign language) will be used for members who are not proficient in English or English may not be their primary language or are hearing impaired. The Medical Interpreter service must have documented professional experience of all staff on file who will be utilized to perform medical interpretation services. This documentation must be available upon request by the contracting agency or other entity.

The Case Management agency applicant must submit a Business Plan, including the 14 items listed above, to the Department of Community Health Specialist prior to completing the enrollment application using the 'Enrollment Wizard' under the "Provider Enrollment" menu at www.mmis.georgia.gov. Completed application should be mailed to:

Department of Community Health
2 MLK Jr. Dr SE
Twin Towers East
Medical Assistance Plans
19th Floor, Atlanta, GA
30304

See Appendix GG, application checklist table regarding CVO. Part II Chapters 600-1000 Policies and Procedures for CCSP/Source General Services Manual

See 105.13 and 106 (LL) Part I Policies and Procedures for Medicaid/Peachcare for Kids Policy Manual to maintain compliance with background screening requirements for fingerprint/ criminal background checks of owners, administrators, onsite managers, directors and direct access employees.

NOTE: Initial and expansion application territory requests are limited to 10 counties maximum or all counties for one specific AAA region.

NOTE: If the applicant is denied, DCH will notify the applicant of the reason for the denial. Applicant

agencies have the right to appeal enrollment denial as indicated in Part I, Policies and Procedures for Medicaid/Peachcare for Kids Manual. An applicant may not re-apply for one (1) year after date of denial.

NOTE: Upon completion of the steps above by the Case Management agency, a site visit of the applicant's agency will be performed by DCH as well as completion of mandatory training of policy and the electronic data system before member referral can begin. Initial approval into EDWP and continued program participation will require monitoring of performance and review of member admission for the new/existing site as sites familiarize with the process flow and all aspects of assessment, level of care, brokering, billing etc. Sample audit(s) will be done by DCH to ensure policy compliance and audit results will determine if admissions to that site need paused while working through a plan of correction.

NOTE: EDWP Case Management utilizes a standardized mechanism by which waiver case managers are certified to provide care coordination to members. All waiver case managers are required to become certified to establish baseline quality performance standards. Certification curriculum will include online module performance testing. Topics will include waiver eligibility and program options, quality management requirements, case management roles and responsibilities and person-centered planning. Existing case management will have 6 months to complete the required certification and new hires must complete training within 60 days from the hire date. DCH also requires attendance by Lead Case Management at quarterly 'Train the Trainer" meetings. Information regarding time/place/date is sent out in advance.

The Case Management serves as a single source of information regarding service options. In addition, the Case Management also arranges and authorizes service(s) provided by enrolled providers.

Case Management must be available 24 hours a day, seven days a week. During non-business hours a contact person (not an answering machine) must be available by telephone. If a change in the comprehensive care plan is needed, the contact person calls the assessing nurse and/or RN for consultation. The contact person must have available a data set which includes client names, addresses, and telephone numbers of clients, service providers and emergency contacts.

Case Management agencies establish and maintain written policies and procedures for clients and staff to follow in the event of an emergency or disaster.

Only qualified individuals may function as Case Management.

NOTE: Billing claims to Georgia Medicaid for reimbursement of case management services provided to Traditional/Enhanced EDWP members became a part of Georgia's Elderly and Disabled Waiver with the approval of the 5-year waiver cycle that began on October 1, 2017.

Case Management agencies will bill code T2022 or T2022SE at a rate of $192.50/$211.50. Billing will be monthly for all **active** clients, including those beginning in the month the initial assessment was performed.

For an initial admission, all the signatures on the level of care/ Level of Care and Placement Instrument are required before you can bill for case management, but you bill for case management services back to the

assessment date.

Billable clients require a monthly contact with a client/caregiver (visit or phone/monthly contact assessment), made by a nurse, *Case Management* ***or staff member plus client Medicaid eligibility and an approved length of stay under a level of care***.

NOTE: Support staff performing monthly contact assessments can only be by phone and not a scheduled visit of a 30 or 90- day review. Consultation with the file's manager, (RN, LPN or CM) is required for follow-up issues.

NOTE: Initial clients withdrawn from the program due to death, a move, requested discharge etc. and have an LOC **approved** by Alliant Health Solutions (AHS) /MD can be billed for the month of the initial visit and up to the month of the discharge/death.

> Example- Initial visit on 2/1/18, submitted to Alliant Health Solutions (AHS) 2/5/18, sent to MD 3/3/18 and returned from MD on 4/1/18 but client died on 3/15/18, the agency can bill for February and March with the completed/approved loc.

If the member is in a nursing home/rehab facility, Case Management billing begins the day after discharge from the facility.

NOTE:
Case Management will contact members a minimum of once each month, either face-to-face during assessment, care plan review or by phone. Documentation is done in the electronic data system in the form of MDS, care plan review or monthly assessment.

NOTE: Case Management level changes (TCM to ECM only) require physician or the agency's Medical Director orders using the change of service letter. If billing already occurred for the current month at the current level, a claim can be edited on Gammis for the current month to the newest established rate or the new rate can start the following month.

NOTE: Case Management service is not subject to cost share collection.

NOTE: There will be an audit requirement for any Case Management agency that requests enrollment in to EDWP or an expansion of their service area. The expansion request will include an application to the Department of Community Health as noted above for new site expansion as well as a business plan that lists the counties to be served by the new/current office.
A negative audit can result in a denial of the expansion and a ban on new admissions applied as corrective action until the agency regains compliance. Providers seeking expansion are required to be in compliance with all applicable laws, rules, regulations, policies and procedures of all services the provider is currently enrolled to provide. DCH will not process an expansion request for a provider against whom there are unresolved complaints/deficiencies cited by Utilization Review/ Program Integrity or other licensing or regulatory agencies. **Newly approved sites may not apply for additional counties for six (6) months after date of approval.**

PROCEDURES

Responsibilities of Case Management include:

- Assessment of client strengths, risks and unmet needs
- Collaborating with client to determine service needs and outcomes
- Planning, arranging, coordinating, and evaluating service delivery
- Brokering services with provider agencies
- Identifying and arranging non-Medicaid resources/services
- When a provider agency is unable to deliver services as ordered in the client's care plan, reporting these situations to the AAA
- Coordinating with provider agencies to assure comprehensive service delivery and thorough communication
- Communicating with client's physician or the agency's Medical Director regarding status changes and health issues
- Assisting the client with obtaining ancillary services such as transportation and durable medical equipment
- Completing Comprehensive Care Plan (CCP) reviews
- Monitoring client health changes and the care provided to assure that services are rendered by the service provider as ordered in the CCP
- Identifying, resolving and monitoring issues related to quality of care and timely delivery of services
- Assuring that clients are free from abuse, neglect of care and exploitation by provider's agents
- Initiating actions to address events which may adversely affect the client's health status
- Initiating discharge planning
- Working closely with clients to be familiar with their needs and preferences
- Being accountable to a client and the direct service delivery system
- Acting as an advocate for a client in the human service bureaucracy and brokering

services

- Assisting clients with appeals.
- Collaborating with D-SNP (Dual Eligible-Special Needs Plan) for CMS requirements regarding shared data elements.

Activities *not appropriate* for Case Management include, but are not limited to the following:

- Instructing providers which funding source, such as Medicare, to bill for service(s)
- Providing direct services, such as Medical Social Services, to a client
- Changing the initial CCP without consulting the nurse who completed the initial assessment
- Updating a diagnosis without requesting a physician or the agency's Medical Director consult
- Making a major change in service without a nurse home visit, except when regulations permit
- Soliciting clients on behalf of providers

Conflict Free Case Management is required by the federal government. DCH restricts agents that conducts the functional assessment and/or case management to also provide services to that individual.

A case management entity is required to adhere to the following characteristics of conflict-free case management:

• ***Separation of case management from direct services***:
Structurally or operationally, Case Management should not be employees of any organization that provides direct services to the individuals. Ideally, conflict-free case management agencies are stand-alone and provide **no** other direct services. This prevents financial pressure for Case Management to make referrals to their own organization or "trade" referrals.

• ***Separation of eligibility determination from direct services***:
Eligibility for services is established separately from the provision of services so assessors do not feel pressure to make individuals eligible to increase business for their organization. Eligibility is determined by an entity or organization that has no fiscal relationship to the individual. In our system, this occurs through the level-of-care determination process.

Case Management does not establish funding levels for the individual:
In the Georgia model, the Case Management's responsibility is to develop a recommended plan of supports and services based on the individual's assessed needs. Ultimately, DCH staff and its agent (Alliant Health Solutions (AHS) will determine whether the care plan is medically necessary. *(For TRADITIONAL/ ENHANCED, funding level is set by the waiver, and individual funding is ultimately under the approval of DCH for medical necessity, this will be reinforced with training to Case Management Agencies.)*

• ***Individuals performing evaluations, assessments and plans of care cannot be*** related by blood or marriage to the individual or any of the individual's paid caregivers, or financially responsible for the individual.

A plan from each Case Management entity that identifies its strategies for conflict-free case management should be included in all company policy manuals.
If the agency feels it is the only provider supplying Case Management and direct support services for an area, please notify DCH for further direction.
If DCH agrees, you will need to identify the protections that are engaged to mitigate conflicts of interest. Each plan should also speak to the development of a written protocol that would be applied operationally to support the adherence to policy.

1824 – TELEPHONE SCREENING ASSESSMENT POLICY

STATEMENT

AAA telephone screening specialist completes a telephone screening to determine a referral's eligibility for the EDWP and to establish priority for face-to-face assessment for the initial care plan.

POLICY BASICS

Traditional/ Enhanced EDWP referrals come from a variety of sources, including the following:

- Applicant and/or family member /care giver /applicant representative
- Hospitals
- Physicians or the agency's Medical Director
- Nursing homes
- Home health agencies
- Programs/Providers for the elderly
- Other community agencies.

Service and Case Management providers or other third-party referrals to the ADRCs will have program information sent by e-mail/ regular mail within 3 business days to member/family applicants. ADRCs will not contact third-party referrals regarding referral updates. To prevent conflict of interest issues, the referral process does not allow for providers to serve as the representative, interpreter, or liaison for applicants. Providers are encouraged to have member/family applicants contact the ADRC directly to complete an application for services. Screening for potential applicants will occur within five (5) business days of referral and be completed within 15 business days after receiving the referral.

All phone inquiries from member/family applicants regarding waiver assistance that are made to the ADRC will be returned in a 24 hour period.

Once an applicant has been telephone screened, the individual is:

- Referred for a face- to-face assessment for the initial care plan OR

- Determined ineligible for Traditional/Enhanced EDWP services OR
- Placed on a waiting list.

To be eligible for Traditional/ Enhanced EDWP, an applicant must meet all eligibility criteria.

If an individual lives in another PSA, the applicant needs to be screened and placed on the waiting list in the area where the client will receive service. An applicant does not have to be a resident of Georgia to be telephone screened.

NOTE: If the applicant is Community Transitions (CT), formerly MFP, the screening is performed in the AAA region in which the client is residing in the nursing home. The current and future addresses are to be noted in the electronic data system with the primary/active address noted as the current nursing home. The screener will complete an alert note to the receiving AAA Program Manager regarding the anticipated future placement of the applicant in the new area.

When placed on a waiting list, an applicant will be re-screened every four months until removed from the list. Re-screening determines if applicant's priority or need for service has changed in the past four months.

PROCEDURES

During telephone screening, complete the following activities:

- Discuss the eligibility criteria with applicants
- Use the DON-R to determine functional eligibility
- Determine if applicants meet Level of Care (LOC) and document criteria in comments section of "Being Alone" or formal case notes
- Use Medicaid criteria to assess financial eligibility
- Complete any additional/applicable advanced assessments (food security and NSI/Nutrition)

NOTE: The use of interpreters is necessary to ensure members are ESL (English as Second Language) are understood in their native language and conflict free case management standards are maintained.

NOTE:
EDWP applicant screening performed by Case Management for SOURCE and the Area Agency on Aging for CCSP as well as monthly contact call policy requirements for Case Managment are to utilize a camera telehealth modality encrypted (end to end encryption) software product with established business agreement that protects PHI (protected health information). PHI is information about health status, provision of health care, or payment for health care that is created or collected by a covered entity and can be linked to a specific individual. Applicant/member or AAA/Case Management with access to landline phone (one way) can be utilized in place of the software requirement. Landline/non internet use is appropriate (copper wires that carry their own power and work during blackouts). Follow up calls not

involving billable service work requires I phone or Android encryption cell settings use or landline. Use of electronic health records, member portal access or app use are to be encrypted (end to end encryption) with business agreement as well.

NOTE:
Clients requesting a move from SOURCE to Traditional/ Enhanced EDWP will be screened by the ADRC and sent for nurse initial assessment without placement on a waiting list. The screening assessment/performance of the DON-R is not necessary for these cases. Input general demographics and process the file to the Case Management.

Advise applicants of all available community resources that may meet their needs.

Use the electronic data system to gather the following client information during telephone screening:

- Demographic information (minimally required includes applicant address/phone, date of birth, SS#, Medicaid ID #, caregiver contact and phone if applicable and Medicaid status type)
- Personal contacts
- DON-R score that determines applicant's priority for initial assessment.

Use the Notice of Status of Request for Services from the Traditional/Enhanced EDWP Services Program form to notify applicants of their Traditional/ Enhanced EDWP eligibility and waiting list status.

Using the appropriate letter, Form 5382, Notice of Denial, Termination, or Reduction in Service from the Traditional/ Enhanced EDWP or Level of Care denial to advise applicants with a **completed** Don-R of denial/removal from the waiting list at the ADRC level.

NOTE: Refer to section 1860 for appeal policy.

Send a copy of the Traditional/ Enhanced EDWP information handout to all applicants upon request.

When having difficulty reaching referrals to complete the telephone screening assessment, use the procedures in Chart 1824.1 to contact referrals:

TELEPHONE SCREENING CONTACT PROCEDURES

IF	THEN
Unable to reach client/caregiver (client/caregiver referral, not third party referral) for telephone screening/re-screening	Document in notes the two attempts to contact by phone (on separate days; not on same date), noting date/time of attempts and whether or not a voice mail was left if applicable.

Partial screening is performed and follow up calls to finalize work are unsuccessful	Mail letter to the client/caregiver requesting follow up needed and supply member with AAA contact information.

NOTE: Faxes, email and other correspondence sent to the ADRC from home health agencies or hospitals for their discharge planning process do not require telephone contact except when requested by a potential client. A letter mailed to the client explaining the AAA/ADRC and services offered is sufficient. Counselors must explain to all callers that individual clients will not be assessed without their knowledge and permission except in cases where the individual cannot give consent, allowing the Counselor to complete assessment with the caller or other representative.

When adding an applicant with income below the SSI limit to the waiting list, use procedures in Chart 1824.2:

APPLICANTS WITH INCOMES BELOW SSI LIMIT

IF	THEN
Applicant's monthly income from all sources is less than SSI monthly limit.	Individual may be a potential SSI recipient. Refer the applicant to the Social Security Administration for SSI eligibility determination Do not refer a potential SSI client to Case Management for assessment for initial care plan until SSI eligibility is determined.
Applicant's monthly income from all sources is less than SSI monthly limit AND individual lives in a nursing home	Individual applies for SSI when discharged from the nursing home.

Applicant is not eligible for SSI due to applicant or spouse's income or resources AND receives Social Security <u>disability</u> benefits **NOTE**: Individuals may receive widows' or early retirement benefits from Social Security without disability being established.	Determine applicant's PMAO eligibility. When funds are available, refer applicant for assessment for initial care plan.
Applicant is not eligible for SSI due to applicant or spouse's income and resources AND applicant is 65 years of age or older	Determine applicant's PMAO eligibility. When funds are available, refer applicant for assessment for initial care plan.
Applicant is not eligible for SSI due to applicant or spouse's income and resources AND applicant is under 65 years of age AND does not receive Social Security <u>disability</u> benefits Applicant is not eligible for SSI for any reason other than income or resources.	Refer the applicant to Case Management for assessment and processing of the level of care validation to Alliant and level of care approval to the Physician/Medical Director. Communicate with the Case Management agency re the needed application with emphasis on the SMEU case with waiver medicaid. DFCS will determine if a SMEU is needed once application is reviewed. Case Management will work to process the initial care plan and collaborate with the member and DFCS for processing of the potential eligibility for EDWP Medicaid.

NOTE: If a client has no Case Management agency preference during screening, and multiple agencies service a particular county of residence for the client, indicate in formal notes that client choice was explained and document the selection made by the applicant. The AAA uses the client choice method to assign a Case Management Service Provider. If the referral was made by a specific Case Management agency, the client will be given to the referring agency unless the client requests not to have that placement made.

<u>Use the signed 'member choice form' when processing the initial assessment to the appropriate case management agency.</u> The form can be uploaded to formal notes in the electronic data system for electronic storage. The ADRC will confirm the choice via a mailed-in form, e-mail, audio file or text message from the member/representative that can be saved, but the choice needs to be confirmed ***<u>in writing</u>*** to the ADRC before the member is referred for assessment. A formal note in the electronic data system can be a last resort when all efforts have been made to obtain written documentation for Case Management choice.

The AAA can send notice of removal from the waiting list if they get no response after a reasonable length of time. The AAA should attempt to make telephone contact with the applicant or other primary contact before sending the letter.

1825 – Traditional/ Enhanced WAITING LIST

POLICY STATEMENT

Depending upon availability of Traditional/ Enhanced EDWP benefit funds, applicants who have been telephone screened and determined eligible for Traditional/Enhanced EDWP may have to be placed on a waiting list for full assessment.

POLICY BASICS

Cost factors and the number of individuals participating in the Traditional/ Enhanced EDWP affect the availability of funds. If no waiting list exists in the area, clients are admitted to the Traditional/ Enhanced EDWP in the order they are referred to Case Management for full assessments.

The Department of Community Health allocates Traditional/ Enhanced EDWP funds to each AAA. The AAA and DCH manages the PSA's service benefit allocation that supports a specific number of Traditional/ Enhanced EDWP clients for a given fiscal year.

The AAA requests Case Management complete assessments in order to properly expend the area's allocation. Before sending referrals to Case Management for face-to-face assessments, AAA's contact waiting list clients to determine if their living arrangements and need for services have changed.

If Traditional/ Enhanced EDWP clients with a current, active LOC or receiving services transfer from one PSA to another, they are not placed on a waiting list in the receiving area, but remain active in the new region.

Clients requesting a move from SOURCE to Traditional/ Enhanced EDWP will be screened by the ADRC, with use of the 'waiver transfer form' and 'transfer supplement' sent by the Source site to the AAA, and sent for the nurse initial assessment without placement on a waiting list. The screening assessment/performance of the DON-R is not necessary for these cases. Input general demographics and process the file to the Case Management.

After coordinating with appropriate Department of Community Health staff, sometimes AAAs admit emergency clients to the Traditional/Enhanced EDWP when other admissions are restricted.

The Elderly and Disabled Waiver/ Traditional/ Enhanced EDWP will admit 234 slots per fiscal year with a confirmed dementia diagnosis. These 234 slots will bypass the wait list at the Aging and Disability Resource Connection (ADRC) beginning in SFY 2018 with assignments per region given by the Department of Community Health.

AAA use Chart 1825.1 to manage waiting lists for Traditional/ Enhanced EDWP services:

CHART 1825.1 – WAITING LIST PROCEDURES

IF	THEN AFTER COMPLETING TELEPHONE SCREENING
There are not budget constraints/no waiting list	Refer applicants on a first-come, first-served basis.
Budget constraints prevent new admissions	Place names of applicants who appear eligible based on the DON-R scores for level of impairment and unmet need for care on a waiting list for assessment.
Budget constraints limit the number of admissions	Refer applicants with the highest DON-R scores and the most days on the waiting list for initial assessments.
Budget allows new admissions	Refer clients for initial assessment based on the highest DON-R scores or by county request of the Case Management agency

Discussion of service options should reflect no duplication in service delivery across fund sources, providers, and types of service without documented explanation in the client record. Examples of this duplication include, but are not limited to, services provided via waiver programs, the Veterans Administration, and community and faith-based organizations. The AAA will provide details in the electronic data system notes to reflect any current receipt of services not associated with EDWP. This will allow the receiving Case Management to coordinate discharge of unneeded/duplicative care while brokering EDWP services.

1826 – INITIAL ASSESSMENT

SUMMARY STATEMENT

Prior to admission into the Traditional/ Enhanced EDWP, each applicant receives a face-to- face assessment from a nurse Case Management.

BASIC CONSIDERATIONS

An initial assessment of the client enables the nurse to:

- Evaluate the client's medical and health status; functional ability; social, emotional and financial factors related to illness; home environment and available resources
- Identify services needed to restore or preserve client health
- Identify ECM/enhanced or TCM/traditional level eligibility
- Identify desirable outcomes for the client based on risk factors and client

choice
- Certify client level of care (LOC)

At initial assessment, the nurse uses the electronic data system care management program to complete the following:

1. Minimum Data Set-Home Care (MDS-HC v9)
2. Comprehensive Care Plan (CCP)
3. Case notes
4. Verification of spelling of client's name, SSN, and Medicare and Medicaid numbers
5. Determination of Need-R (questions are incorporated into the MDS-HC which derives the DON-R score)
6. Nutritional Screening Initiative (NSI)
7. Applicable advanced assessments (Slums, PHQ9, Fall Risk, MMSE) etc,
8. Task lists (Service specific, Client/caregiver and Case Management)
9. Emergency Disaster Plan/Discharge Plan

The following Traditional/ Enhanced EDWP documents are completed at initial assessments:

1. Level of Care and Placement Instrument
2. Authorization for Release of Information and Informed Consent (signature page)
3. Notice of Right to Appeal Form (5381)
4. PMAO Financial Worksheet, if applicable
5. Client Referral Form – Home Delivered Meals and Appendix C HDM policy manual form, if applicable
6. Nutrition Screening Initiative Checklist
7. Client's Rights and Responsibilities
8. Authorization for Release of Information Form, 5459, if needed

NOTE: Form 5459 can be downloaded from the Georgia Medicaid Management Information System/GAMMIS at https://www.mmis.georgia.gov/portal/default.aspx

NOTE: Traditional/ Enhanced EDWP / and SOURCE transfers/admits will follow policy in section 1851.

NOTE: Members returning to Traditional/ Enhanced EDWP within the same fiscal year/reinstatements or returning while the existing LOC PA is still active, do not require a new MDS for entry. The client will be processed via the ADRC as usual.

- If the current PA will expire in 90 days, an initial MDS assessment is required for Alliant Health Solutions (AHS). If the previous PA will not expire in 90 days, a shell MDS can be created for programmatic purposes but not sent to Alliant Health Solutions (AHS) and the existing PA from the previous assessment will maintain the member eligibility. In both scenarios, code these MDS papers as an initial.
- During the initial visit, a nurse review can be done in the electronic data system upon completion of the home visit. Care to the member can be brokered immediately upon care plan completion with the use of the previous MDS PA.

- ➢ The nurse is to evaluate for service needs during this initial home visit and follow policy for brokering upon return to the office. **Providers may begin services with the use of the previous MDS PA and updated nurse care plan. Any new service would be brokered once the signed change of service letter is received from the physician or the agency's Medical Director and the new level of care is locked.**
- ➢ The Case Management will follow with a 30- day visit.

NOTE: All necessary/applicable documents listed above (#1-8) continue to be required for chart processing.

PROCEDURES (STEP 1)

Use the LOC page, MDS-HC, DON-R, and CCP to complete a comprehensive, standardized assessment which

- Determines the applicant's degree of functional impairment and need for therapeutic services
  - Qualitatively documents the presence or absence of illness, problems, and /or needs to support that an applicant meets the intermediate level of care (LOC) criteria for nursing facility care
- Compiles pertinent information about the applicant's social and functional status, physical and mental condition, nutritional status, and adequacy/inadequacy of support system and physical environment
- Functions as the initial care plan for the Case Management, records initial service brokering, and enables the Case Management to assure the appropriateness of care
- Serves as a Medical Plan of Treatment for all EDWP providers except for Medicaid home health agencies

Additionally, the nurse uses advanced assessments, as indicated, at the initial assessment to establish baseline functioning for individuals with cognitive loss, individuals who have signs and symptoms of depression, individuals at risk for falls and/or home environmental concerns.

Each Case Management agency designs a Traditional/ Enhanced EDWP folder to be left in an easily accessible location in the client's home during initial assessment. The contents include, but are not limited to:

1. Contact information for the Traditional/ Enhanced EDWP staff:
   - Case Management agency's number for 24 availability
   - Case Management's name, address and phone number
   - AAA name, address, and phone number
   - 911 or emergency number

NOTE: Type these numbers in a large font on a single sheet of paper for the client's use. Explain to the client/representative when to call these numbers.

2. Traditional/ Enhanced EDWP Fact Sheet that includes Traditional/ Enhanced EDWP

process, financial eligibility, criteria and available services

3. Notice of Right to Appeal Decisions, Form 5381
4. Traditional/ Enhanced EDWP brochure
5. Understanding Medicaid and Home and Community Services booklets
   NOTE: can be a paper insert within the folder with the web address only vs booklets. Use the following web address: www.mmis.georgia.gov, "Member Information", "Member Notices" in the dropdown.
6. Client Rights and Responsibilities form
7. Cost share brochure, if applicable
8. Consumer Direction Option for Personal Support Services Fact Sheet
9. Information about Elder Abuse, Neglect and/or Exploitation *(distributed initially and at annual recertification) - copy kept in member file*
10. Emergency Preparedness assessment copy/completed
11. Discharge Planning assessment copy/completed
12. Estate Recovery brochure (**for PMAO and SSI applicants**) https://medicaid.georgia.gov/documents/medicaid-fact-sheets
13. HIPAA Notice of Privacy Practices DCH

The nurse uses the following steps to conduct the initial assessment and LOC determination:

Contact client/representative to schedule the home visit for initial Assessment

- For emergency situations, use Chart 1826.2
- For clients who live in one PSA, but will receive services in another area, the PSA where the client resides may complete the initial assessment for the other area. The Case Management agencies communicate to determine which PSA completes the initial assessment

NOTE: Any applicant or member of the E&D Waiver Program for whom English is not the applicant's/member's primary language must be provided interpreting services in their native language for all initial assessment for program admission, annual reassessment, or any time when a change in condition will require a new evaluation of need. The interpreting services must be provided by an independent, conflict free agency, organization or contractor with no organizational affiliation to the case management or service provider agency **or relationship to the applicant/member**. A documented record of the interpreter or interpretation agency, including all contact information (i.e. complete name, address, phone number and email), must be maintained by the agency or service provider agency that secured the interpretation service and will be made available to DCH upon its request as part of the applicant's/member's file. If the applicant's or waiver member's care is managed by a legal guardian, the interpretation requirements outlined hereinabove will also apply to the legal guardian.

The use of Medical Interpreters is necessary to ensure members are ESL (English as Second Language) are understood in their native language and conflict free case management standards are maintained.

NOTE: For purposes of monthly reporting, the ADRC region listed in demographics at the time the programmatic report is run will receive the credit for the assessment performed for courtesy assessments.

The area performing the courtesy work will upload the file to Alliant Health Solutions (AHS) for verification of the level of care unless a request by the receiving area is made not to. If the area performing the work does do the upload, a request for transfer must be made to Alliant Health Solutions (AHS) on behalf of the receiving area.

The area performing the courtesy will bill Gammis for work performance based on the month of the assessment. The area receiving the client will bill the month after and ongoing.

Initial clients no longer require service to begin in the PSA in which they were assessed in order to transfer to the receiving area, regardless of the DON-R score at initial assessment.

PROCEDURES (STEP 2)

Conduct a comprehensive, face-to-face interview with a prospective client/representative at the applicant's residence, hospital, long-term care facility or other appropriate site, using the Level of Care page, MDS-HC and CCP.

- Explain the Traditional/ Enhanced EDWP to applicant/representative
- Obtain client's signature on the LOC page, Authorization for Release of Information and Informed Consent (provide explanation of terminology), Right to Appeal and Rights and Responsibilities.
- Use the Notice of Right to Appeal Decisions regarding EDWP, Form 5381, to inform applicant of appeal rights and responsibilities
- Discuss the information on the Client Rights and Responsibilities form

If client is a Medicaid recipient, examine the Medicaid card and record the Medicaid client identification number

PROCEDURES (STEP 3)
Determine MAO/PMAO eligibility status, using procedures in Chart 1826.1 for MAO and PMAO applicants:

CHART 1826 – ASSESSMENT PROCEDURES FOR MAO AND PMAO APPLICANTS

IF	THEN
Applicant is MAO or PMAO	Follow above assessment procedures. In addition, take the following steps: • Use cost share brochure to inform applicant of cost share potential and maximum estimated cost share • Discuss the Medicaid eligibility process with the client and/or family • Advise applicant that DFCS determines Medicaid eligibility and exact cost share amount • Complete the Potential Traditional/Enhanced EDWP Medicaid MAO Financial Worksheet • Applicant signs the Statement of Intent: Cost Responsibility, with the estimated cost share indicated
Applicant is neither eligible for Medicaid nor PMAO	• Complete Notice of Denial, Termination or Reduction in Services, Form 5382 to deny application • Do not complete the assessment, document the client's decision in case notes

NOTE: Complete the Potential Traditional/ Enhanced EDWP Medicaid MAO Financial Worksheet for applicants not already receiving Medicaid benefits who are seeking Traditional/ Enhanced EDWP admission. Use the worksheet to determine potential MAO clients and to determine whether applicant resources are within the appropriate limit.

Procedures (STEP 4)

Using all information, determine applicant's status as follows:

- Is not financially eligible for Traditional/ Enhanced EDWP
- Requires immediate institutional care without further assessment
- Chooses nursing facility placement over admission to Traditional/Enhanced EDWP and does not require further assessment

If applicant is determined ineligible at the initial assessment:

- Upload the completed assessment to AHS for validation along with the assessing nurse information in notes and the MDS (which includes the ILOC Crosswalk) regarding ineligibility
- Advise the applicant of appeal rights and responsibilities if AHS denies eligibility.
- Follow process in sections 1860-1865 regarding appeals
- Refer the applicant/representative to other community services or nursing facility

If applicant is determined eligible for the Traditional/ Enhanced EDWP:

- Use the MDS-HC to complete a comprehensive evaluation of the applicant's medical status

and health functional ability and available resources. Analyze and interpret medical and social information as compiled. Obtain additional information as needed, requesting medical record information from the physician or the agency's Medical Director, using the EDWP Physicians Evaluation form.

While medical record submission is not required for all level of care reviews, any reviews that fall in the following categories may be supported by medical records:

- Assessments that reflect functional impairment not clearly associated with a medical diagnosis
- Assessments that reflect one or more behavioral health diagnoses with functional impairment not clearly associated with a medical diagnosis
- Assessments that reflect diagnoses not typically expected to result in long term functional impairment such as hip fracture or knee replacement

Alliant Health Solutions and/or DCH staff may request and/or retrieve medical records to support any level of care determination. The request is for the purpose of determining eligibility. Information may include hospitalization information, medical equipment needs, previous treatment, and medical history.

PROCEDURES (STEP 5)

Determine appropriate services and setting necessary to maintain or improve applicant health and functional status.

PROCEDURES (STEP 6)

Determine if the client/representative has or can obtain supplies (soap, water, or other supplies) necessary to benefit from Traditional/ Enhanced EDWP services ordered. If necessary, ask client and/or family to arrange for obtaining needed supplies

PROCEDURES (STEP 7)

Develop a realistic, cost-effective, client-centered and individualized Comprehensive Care Plan (CCP). Encourage the client/representative to assume an active role in the development of the CCP. Consult with applicant's physician or the agency's Medical Director for medical information and recommended treatment for the CCP

NOTE: Alliant Health Solutions (AHS) provides validation of the level of care eligibility and the applicant's physician or the agency's Medical Director reviews LOC page and CCP of the assessment and signs LOC page before RN certifies the LOC.

PROCEDURES (STEP 8)

Develop the initial discharge plan in consultation with the client/representative, the client's physician or the agency's Medical Director, other involved service agencies, and other available local resources, considering the following factors:

- client preference
- problem identification
- anticipated progress
- evaluation of progress to date
- target date for discharge (difficult to assess)
- identification of alternative resources for care after discharge

PROCEDURES (STEP 9)

Document the discharge plan as designated on the CCP, introducing the discharge planning checklist. Complete the NSI. If necessary, consult with a Registered Dietitian when assessing the client's nutritional needs.

PROCEDURE (STEP 10)

Refer to resources, as appropriate

For clients who will receive Traditional/ Enhanced EDWP HDM, with client's permission, conduct refrigerator/freezer check to assure that units are able to maintain the proper food temperature. Note the diet type on the LOC page of the assessment and if ordering HDM, completes the Client Referral Form- Home Delivered Meals.

PROCEDURE (STEP 11)

Determine Intermediate LOC eligibility in the electronic data system with use of the Level of Care Crosswalk.

NOTE: The nurse comprehensive evaluation of the applicant's medical status and health functional ability, reviewed by the RN, and combined with medical records and social information returned from the physician or the agency's Medical Director or the EDWP Physicians Evaluation form is used to determine eligibility to proceed to validation at Alliant Health Solutions (AHS).

PROCEDURES (STEP 12)

Upload the following documents to Alliant Health Solutions (AHS) via the MMIS for validation of the LOC:

- scanned Level of Care and Placement Instrument
- ADRC Don-R
- Alliant Health Solutions (AHS) Assessment reports in PDF (including MDS (which includes the ILOC Crosswalk), case notes, and medications)
- Client demographics report
- Applicable advanced assessments
- Physician or the agency's Medical Director medical records documentation/ EDWP Physicians Evaluation form

NOTE: If member resides in an ALS at the time of initial assessment, receives an LOC denial and wishes to appeal, submit a Gateway application with an unapproved LOC. An appeal win by the member will allow for processing of protected months of Medicaid to the original MDS visit date. Submit a new application every 3 months until a final hearing determination is made to cover each month of waiver care. Keep DFCS aware of the appeal and submit the approved/signed LOC once available.

NOTE: When Alliant Health Solutions (AHS) issues a second LOC approval that extends a previous short term loc (6 mos) you can attach the contact us documentation to a EDWP Notification Form for each provider for them to keep a hard copy for their files. Submitting a second LOC to the MD is an option, dating the new LOC upon the termination of the previous short term loc. Client would need to re-sign with a new date and the new LOC extension can be listed at the bottom of the Level of Care and Placement Instrument. Submit all completed copies to each provider.

PROCEDURES (STEP 13)

Send the validated Level of Care and Placement Instrument Service Order and LOC page to client's physician or the agency's Medical Director. The physician/nurse practitioner or the agency's Medical Director completes, signs, and returns the documents to the Case Management.

NOTE: Submit the *ECM DM Physician letter* initially and annually (for TCM/Traditional Case Management) to the primary care physician if the Level of Care and Placement Instrument is signed by the agency's Medical Director. Submit the *ECM DM Physician letter* initially and every 6 months for ECM/Enhanced Case Management.

PROCEDURES (STEP 14)

RN certifies the LOC – Length of Stay will not exceed 365 days beyond the LOC validation date Use

procedures in Chart 1826.2 for applicants in emergency Situations

CHART 1826.2 – ASSESSMENT PROCEDURES FOR EMERGENCY CASES

IF	THEN
No other service options are available to applicant OR Immediate institutional placement is the only alternative other than Traditional/Enhanced EDWP	Consider an emergency placement. The applicant must however, meet Traditional/ Enhanced EDWP eligibility criteria for emergency placement and hold the highest score on the DON-R assessment

The PSA has a waiting list for Traditional/Enhanced EDWP admissions	Work with the AAA/Case Management agency/facility Staff/APS to determine availability of funds for emergency placement
The AAA agrees to admit the applicant and the Case Management determines that the applicant is eligible for emergency placement	1. Review available medical and social information from hospital discharge planner, nursing home, or other institution, private physician, health care providers, family or friend 2. Set up an appointment to complete the initial assessment within two working days from the date of the telephone screening 3. Complete initial assessment 4. Discuss with appropriate parties, the client's need for emergency services (e.g., client's physician, hospital discharge planner, DFCS, the provider with whom services are being brokered)
Emergency placement occurs	Determine and document in applicant case notes the criteria used to determine the need for emergency placement

EXAMPLES OF APPROPRIATE EMERGENCY ASSESSMENTS
for Traditional/Enhanced EDWP ADMISSION:

- Impending discharge from an acute care facility with no caretaker, home health services, or other community services available
- Need for immediate relocation of a person who resides in a nursing facility, personal care home due to natural disaster, or other crisis
- Adult Protective Services client
- Caretaker incapacity or unavailability

1827 – COMPREHENSIVE CARE PLAN

POLICY STATEMENT

The Comprehensive Care Plan (CCP) is the Case Management's order for EDWP services.

POLICY BASICS

The CCP provides the following:

- Directions for the agency or person who will provide needed services
- Client focused goals
- Expected changes in client capabilities at a specific future time.

The nurse/ Case Management develops the initial CCP but involves the client/caregiver in decisions to the extent possible. The nurse uses input from the agency RN, the SSW, physician or the agency's Medical Director, provider(s) and client/family to develop the initial care plan. Case Management develop subsequent CCPs at reassessments and reviews.

Each CCP includes the following:

- Statement of client problems and needs
- List of services needed by the client to remain in the community
- A monthly total of needed service units
- Estimate of duration of services
- The CCP includes other formal services such as Medicare home health and services provided by informal caregivers and community resources

Case Management may <u>not</u>:

- Order services on an "as needed" (PRN) basis
- Admit applicants whose needs are fully met by Medicare home health services or hospice care.

PROCEDURES

During CCP development, conduct the following activities:

1. Determine client needs based on observations of individual functional capabilities and information obtained during assessment. Discuss client problems and needs with client and appropriate family members. If it is obvious that the client does not understand the Traditional/ Enhanced EDWP or may not remember what the Case Management says during an interview, include the caregiver.

NOTE: If a client does not want the caregiver present during the interview, or the caregiver refuses to allow a client to be interviewed alone, the Case Management must judge whether these requests can be honored and discuss them with those involved before sharing information.

2. Explore existing client support system and informal services. Investigate with caregiver what services care giver or others might provide that they do not presently provide. The caregiver may be very willing to give more help but may lack necessary knowledge or skill. If appropriate, assist caregiver in obtaining training needed to provide additional assistance. Determine if caregiver is able/willing to continue providing caregiver level of service.

EXAMPLE: The provider may need to teach a care giver to fill insulin syringes to give injections to a client.

Obtain client permission to investigate informal services. Case Management may discover people who have been providing support services or who are willing to help meet care plan goals.

3. Include client in decision about services needed. Consider all services needed by a client.

4. With the client, set specific goals in the CCP. Measurable goals and objectives can help motivate a client and/or caregiver and can help provide a sense of accomplishment and increased competence when they are met. It is important that everyone involved understands what is expected.

5. Develop and use community resources to meet client needs. Maintain a list of available resources. Coordinate with available Information and Assistance systems. In areas where resources are unavailable, coordinate with the AAA to help develop services and resources to meet client needs.

6. Order units of service on a monthly basis. Use frequency to specify the weekly schedule for service delivery.

7. Determine if client requires Medicaid home health services. If the physician or the agency's Medical Director writes orders for the provider to include occupational, physical, and speech therapies, the order must be time-limited.

NOTE: If Medicaid home health services are ordered, specify the service(s).

8. As necessary, confer with mental health professionals to complete the initial CCP for any Traditional/ Enhanced EDWP client with a secondary mental health, mental retardation, or developmental disability diagnosis. Incorporate recommendations from a psychiatric or psychological report into the CCP.

9. Use reimbursement rates provided by DMA to determine the cost of client services.

10. Coordinate Traditional/ Enhanced EDWP services with informal and other formal services that the client receives.

NOTE: Community services or other services not reimbursed through the Elderly and Disabled Medicaid Waiver are listed in the electronic data system in the referral and support tracking within assessments.

1828 – COST LIMIT GUIDELINES

POLICY STATEMENT

The cost of Traditional/ Enhanced EDWP services provided must be less than the established cost guideline. Georgia's Elderly and Disabled Waiver, of which Traditional/ Enhanced EDWP is a part, allows the program to provide services up to 105% of the Medicaid cost of nursing home care for up to 2 months for a member in an emergency. This amount changes yearly per established waiver costs.

POLICY BASICS

Costs include waivered services reimbursed by Medicaid. The calculation of cost limits excludes:

- Service costs covered by the MAO client's cost share
- First 50 visits from Medicaid home health.

There is a set monthly cost limit per individual in the Traditional/ Enhanced EDWP. Individual cases may exceed this amount only with approval from the Department of Community Health.

PROCEDURES

Use reimbursement rates provided by DMA to estimate the cost of the client's Traditional/ Enhanced EDWP services on the CCP. Any costs between $3,000.00 and $5,000.00 should be evaluated locally by the Case Management using an internal established review process. Cost estimates (after liability deductions) exceeding the DCH established $5000.00 per month threshold must be approved by DCH Case Management specialists prior to care plan implementation.

A (2) two- tiered level review will take place at the Case Management and DCH level for all client care plan frequency and service changes/additions exceeding $5,000.00 prior to the requested care plan implementation.

Level 1- Internal review by the Lead Case Management to include:

a. A demonstration by the client/family regarding changes that have taken place to reflect the need for approval of the request, including documented communication with the

participant's physician or the agency's Medical Director confirming the need for the changes when pertaining to client status change. What is the basis of the need? What has changed to warrant the need? If the change is due to a loss of informal supports or change in environment, provide detail and whether the change is permanent.

b. What non-waivered options are available that could supplement the existing waivered care in place?
c. What are the perceived risks to the client (health and safety or nursing home placement) that exists if the full request is not obtained?

Level 2- Review of the increase/changes by the DCH Specialist.

Service changes/increases are to be re-evaluated after a period of three months or during 30 day and quarterly review visits to determine appropriateness of costs related to continued client condition change. A review during home visits is to be completed for evaluation of service appropriateness.

NOTE: Denials of increases should also include documentation with the client/family regarding their understanding of the denial and information given to them should they request a higher level communication with DCH staff.

Use the Chart 1828.1 to assist in determining the cost- effectiveness of services:

CHART 1828.1 COST LIMIT GUIDELINE PROCEDURES

IF	THEN
Applicant appears to be eligible, services are below waiver cost recommendation, and applicant chooses to enter the EDWP	Inform applicant of potential Traditional/ Enhanced EDWP eligibility and arrange for Traditional/ Enhanced EDWP and, if ordered, Medicaid home health services to begin.
Applicant chooses to enter Traditional/ Enhanced EDWP service AND Costs exceed waiver cost recommendation for a specified time, 2 months to 3 months	Inform applicant of potential Traditional/ Enhanced EDWP eligibility. Arrange for Traditional/ Enhanced EDWP service and, if ordered, Medicaid home health services to begin for applicant.
Applicant chooses to remain in community and chooses Traditional/ Enhanced EDWP AND Services on CCP indefinitely exceed waiver cost recommendation Traditional/ Enhanced EDWP services would be less than or more than the waiver cost recommendation AND Applicant chooses to enter a nursing facility	Discuss situation with Lead Case Management to determine if applicant is appropriate for the Traditional/ Enhanced EDWP, nursing home placement or other community-based services. Do not complete application process for Traditional/ Enhanced EDWP.

1829 – CLIENT CHOICE OF Traditional/ Enhanced EDWP PROVIDER

POLICY STATEMENT

Traditional/ Enhanced EDWP clients may choose their Traditional/ Enhanced EDWP service providers.

POLICY BASICS

Case Management gives clients an opportunity to choose their Traditional/ Enhanced EDWP service providers when they enter the program, change service providers, or when a new service is added.

Factors affecting client choice are as follows:

- Doctor's recommendation for services
- Specific client needs which affect service availability (e.g., need for week-end or evening service)
- Availability of services
- Provider chosen is not enrolled as a Traditional/Enhanced EDWP provider.

PROCEDURES

The nurse/ Case Management uses these procedures to offer and document client's choice of Traditional/Enhanced EDWP provider:

1. Ask client to select the provider for each service recommended in the CCP. Consider whether recommended service is available in client's county. Indicate on the CCP that client selected a provider and list name(s) of provider(s) selected.
2. If the client's physician or the agency's Medical Director specifies a preference for a particular Traditional/ Enhanced EDWP provider for Traditional/ Enhanced EDWP services, inform the client of the recommendation. Advise the client whether the recommended provider delivers services included on the care plan. Ask the client to make the final choice regarding the service provider.
3. If a provider referred the client to Traditional/ Enhanced EDWP, ask the individual if the referring provider is the provider of choice.
4. If a client has no provider preference, indicate on the CCP that client choice is the selection method. The Case Management team then uses the client choice method to assign a service provider.

NOTE: Case Conference assessments are performed in the electronic data system with the client/caregiver and Traditional/ Enhanced EDWP service specific agency prior to the rebrokering of a client from an agency. The conference can be telephonic. The client can choose not to participate. The conference intent is to allow all parties to communicate and resolve outstanding issues, thus, preventing billing overlap due to missed communication.

1830 – LEVEL OF CARE SUMMARY

STATEMENT

The Intermediate Level of Care (LOC) determination for EDWP is based on the medical criteria used by Department of Community Health (DCH), Division of Medical Assistance (DMA) to establish an individual's LOC certification for nursing facility placement. Through contractual agreement with DCH, the Alliant Health Solutions (AHS) provides validation of level of care eligibility for all Georgia Elderly and Disabled waiver clients.

BASIC CONSIDERATIONS

LOC determination is a function of the assessment process. Licensed nurses engage the client in a face to face assessment at which time information and observations are documented in the Minimum Data Set – Home Care (MDS-HC). Work performed by a Licensed Practical Nurse (LPN), must be under the supervision of the agency RN.

Traditional/ Enhanced EDWP eligibility requires an applicant/client to have a current approved LOC assigned by the Case Management RN on a LOC page after the physician or the agency's Medical Director has signed the LOC page.

Since DCH/DMA recovers Medicaid funds paid to a provider for a client without a certified LOC, a new LOC must be secured prior to the expiration of the previous LOC. A LOC length of stay may be approved for less than three hundred sixty-five (365) days but no LOC length of stay may be approved for more than three hundred sixty-five (365) days.

For initial assessments conducted on March 1, 2018 or after, Alliant Health Solutions (AHS) will approve the length of stay to begin with the day the assessment is conducted. This will allow case management to be covered under a length of stay for a level of care from the date of the assessment.

Beginning 1/1/2019, ALS services will be covered under a length of stay for a level of care from the date of the Case Management Nurse assessment/Alliant PA approval date or member date of admission to ALS if after the PA approval date.

- Immediate notification of the initial assessment visit to the ALS G home owner/manager or ALS F management agency is needed for them to begin their required supervisory work in anticipation of Medicaid reimbursement.

For reassessments conducted within 90 days before or 90 days after the expiration date of a length of stay, Alliant Health Solutions (AHS) will continue to approve the new length of stay to begin with the day after the last day of the expiring length of stay.

For reassessments conducted more than 90 days after the expiration date of a length of stay, Alliant Health Solutions (AHS) will approve the new length of stay to begin with the day the assessment for the new length of stay was conducted.

The RN bases the LOC decision on information collected during the home visit, the physician or the agency's Medical Director, and from other sources.

PROCEDURES

RN or LPN completes a face to face interview with the client and completes the MDS-HC, documenting comments within the assessment tool and completing the LOC Crosswalk within the case management software system.

After assessment and review of the level of care, a case not meeting eligibility will be recommended for denial/termination- see section 1860 and 1861. If the denial reason is regarding level of care, the RN will process the file for a second level review/validation by Alliant Health Solutions (AHS). A case meeting eligibility will proceed to validation at Alliant Health Solutions (AHS).

The nurse or designee uploads the following to Alliant Health Solutions (AHS) through the Medicaid Management Information System (MMIS) portal:

1. Scanned copy of the Traditional/ Enhanced EDWP Level of Care and Placement Instrument
2. ADRC Don-R (Initial assessments only)
3. Alliant Health Solutions (AHS) Assessment Reports in PDF (including MDS (which includes the ILOC Crosswalk), case notes, medications and diagnosis)
4. Client detail report
5. Applicable advanced assessments
6. Applicable physician or the agency's Medical Director documentation

NOTE: All assessments completed by LPN staff must be reviewed by an RN prior to submission to Alliant Health Solutions (AHS) and to comply with the Georgia Nurse Practice Act

Alliant Health Solutions (AHS) will assign a prior authorization (PA) number to each submission as an identifier and notify the Case Management agency electronically of the outcome:

- Approved LOC
- Technical Denial (information needed)
- Denied LOC

Once validated by Alliant Health Solutions (AHS), the client LOC is approved for a ***maximum*** length of stay (LOS) of three hundred and sixty-five (365) days, beginning on the date of validation at Alliant Health Solutions (AHS). In some cases, the LOS may be approved for a shorter duration.

NOTE: When Alliant Health Solutions (AHS) issues a second LOC approval that extends a previous short term loc (6 mos) you can attach the contact us documentation to a EDWP Notification Form for each provider for them to keep a hard copy for their files. Submitting a second LOC to the MD is an option, dating the new LOC upon the termination of the previous short term loc. Client would need to re-sign with a new date and the new LOC extension can be listed at the bottom of the Level of Care and Placement Instrument. Submit all completed copies to each provider.

Upon receipt of LOC validation from Alliant Health Solutions (AHS), Case Management will submit the Level of Care and Placement Instrument to the client's physician or the agency's Medical Director for his/her signature to attest to the client's LOC eligibility and approval of the plan of care.

When the signed Level of Care and Placement Instrument is received from the physician or the agency's Medical Director, the RN CM must sign the document to certify the Intermediate Level of Care within twenty-four hours or no later than the following business day.

Levels of care must be re-evaluated and certified at least annually (within twelve (12) months to maintain eligibility in the EDWP. The nurse begins the LOC re-evaluation at least three months prior to the expiration of the current LOC.

NOTE: The RN uses the Intermediate Level of Care Criteria (within the electronic MDS assessment) to determine the potential LOC eligibility for an applicant/client. Individuals who clearly do not meet LOC criteria are still sent to Alliant Health Solutions (AHS) for validation and denial/termination/appeal procedures are initiated by AHS if the denial is agreed upon by AHS.

Use Chart 1830.1 to determine if a situation requires a new LOC and full assessment:

– LEVEL OF CARE SPECIAL CONSIDERATIONS

IF	THEN
Client enters a nursing facility or certain hospital units, (e.g., hospital swing beds, transitional care units, sub-acute units, and extended care units)	DMA-6 is completed by NH and physician. **NOTE:** Case Management contacts facilities to determine if the client received a level of care for admission. If a DMA 6 is certified for institutionalization the EDWP Level of Care can resume upon the clients return to the community. The EDWP RN/LPN performs a home visit for care plan evaluation, performance of the EDWP Modified Reassessment and completion of the physician's order using the change of service letter for any service additions that differ from care received prior to the nursing home stay.
Client is terminated from the EDWP and later re-enters the program	RN/LPN assesses and RN determines LOC before services may resume. If previous LOC is active at Alliant Health Solutions (AHS), client is reinstated and care resumes with
Client's condition shows significant change, or medical condition/support system changes	RN/LPN performs a home visit for care plan evaluation and the possible need for service changes/additions.
Client does not receive any waivered service within 2 months (60 days) after LOC is validated	RN/LPN performs a home visit for care plan evaluation and the possible need for service changes/additions
Client is discharged from nursing home within sixty (60) days	RN/LPN performs a home visit for care plan evaluation and the possible need for service changes/additions.

1831 – TRIAGE

POLICY STATEMENT

Case Management makes provisions for continuing client service at a safe level in the event of an emergency or disaster that would result in interruption of client service(s).

POLICY BASICS

Case Management agencies establish and maintain policies and procedures for assuring that a system of contingency plans for emergencies or disasters are in place. These plans assure back-up care when usual care is unavailable and the lack of immediate care would pose a serious threat to health, safety, and welfare of clients enrolled in the Traditional/ Enhanced Community Care Services Program (EDWP). These policies and procedures include:

- Delivery of service to clients
- Assignment of responsibilities to staff
- Names and phone numbers of Case Management
- Notification to attending physicians or the agency's Medical Director and others responsible for residents/clients
- Arrangement for transportation and hospitalization
- Availability of appropriate records
- Alternatives to current living arrangements
- Emergency energy sources.

Emergencies include, but are not limited to, the following:

- Inclement weather (i.e., heavy rains and snow storms)
- Natural disasters (i.e., flood, tornado, hurricane, and ice storms)
- Major industrial or community disaster (i.e., power outage, fire, explosion, and roadblocks)
- Agency employee illness or staffing shortage affecting significant number of employees or clients
- Damage, destruction or fire at the agency's location

- Remote areas where transportation would be limited

- Suspected abuse, neglect or exploitation.

A registered nurse, LPN or social services worker may assign a triage level.

PROCEDURES

Use the following guidelines to assign triage levels.

Level one clients meet the following criteria:

- Require only minimal amount of care
- Require less complex treatments, and/or observation, and/or instruction
- Provide self-care, ADLs or has a willing and capable caregiver
- Do not exhibit any unusual behavior problems.

Level two clients meet the following criteria:

- Require an average amount of care
- No longer experience acute symptoms
- Require periodic treatments, and/or observation, and/or instruction
- Require some assistance with ADLs, up and about with help for limited periods; or have willing and capable caregivers
- Exhibit some psychological or social problems.

Level three clients meet the following criteria:

- Require an above average amount of care
- Require daily treatment, and/or observation, and/or instruction
- Have willing caregivers whose capabilities are limited
- Require assistance with ADLs
- Ambulate with the assistance of two people
- Exhibits disorientation or confusion.

Level four clients meet the following criteria:

- Require a maximum amount of care and have no caregivers in the home
- Exhibit acute symptoms
- Confined to bed
- Require complete care
- Require treatment and/or procedures necessary to sustain life.

NOTE: Guidelines for triage levels include but are not limited to the above criteria.

Evaluate each client and assign a triage level at initial assessment, Comprehensive Care Plan (CCP) review, and reassessment. Document triage level in the comment section of the CCP.

NOTE: Waivers for desk reviews are not appropriate for triage levels three and four.

If needed, consult with providers to assign or change triage levels.

1832 – CONFIDENTIALITY

POLICY STATEMENT

Any information related to a client is confidential. Release of this information to unauthorized persons or agencies is strictly prohibited.

POLICY BASICS

Traditional/ Enhanced EDWP case records contain both social and medical information of a sensitive nature and by definition are highly confidential.

The *DCH Administrative Policy and Procedures Manual, Volume II*, Section II(A)(2) states: "Records which contain confidential information must be specifically labeled, handled, and stored in such a way as to guard against accidental disclosure."

This policy on confidentiality of records is applicable to DCH employees, the AAA and its subcontractors, and all others involved in Traditional/ Enhanced EDWP service delivery under paragraph number 303 of the DCH contract "Confidentiality - Individual Information".

There are some situations, however, in which the confidentiality of client information cannot be honored. Any information indicating that a client is a danger to self or others does not fall, by law, under confidentiality (see references below).

For example, if a client threatens suicide, the professional is bound by law and by ethics to communicate this information to the proper authorities. Cases in which a client indicates harm to self or others are difficult to deal with, and discussing such situations with a supervisor is a necessity.

PROCEDURES

The AAA staff and Case Management agencies assure confidentiality of case records by requiring that:

- Staff members do not remove case records from the office for any reason except when required by the Administrative Law Judge, Office of State Administrative Hearings, or by subpoena

- Staff members file and lock case records at the close of business each day and electronic records are password protected lap top computers.

- Staff members do not share case record information with any other agency or person without a signed Authorization for Release of Information, Form 5459 from the client. In the case of a deceased Traditional/ Enhanced EDWP client, information is not shared without a written release from the executor of the estate, attorney, etc., stipulating who may obtain information and includes a copy of the letter of administration issued by the probate court. If the person requesting information is not representing the estate and cannot provide the appropriate release and letter of administration, no information may be released without a subpoena.

1833 – REPORTING AND INVESTIGATING INCIDENTS

POLICY STATEMENT

Each Case Management Agency assures that necessary safeguards are in place to protect the health and safety of participants in the Traditional/Enhanced EDWP Services Program.

PROCEDURES

NOTE: As of 4/1/2020, refer to Part II Chapters 600-100 Policies and Procedures for CCSP and SOURCE General Services Manual, 601.6 and below for reporting of incidents and hospitalizations for all areas working in the online reporting system.

It is recommended that each provider should designate an authorized individual to review the incident report, the results of the Follow-Up and Interventions report, and corrective action plans for accuracy and completeness prior to submission to the Department.

One form may be used to record multiple incident types if they relate to the same overall incident. When an incident involves more than one waiver member, an incident report must be completed for each waiver member.

See Appendix CC for definitions of reportable incident types.

Reporting of Incidents

Note: The responsibility for submission of an incident report falls on the first person to witness or discover the incident regardless of location or whether during the point of service. If the reporting provider is the direct service provider, the case manager will be notified of the incident by the confirmation email of the submission of the incident. The case manager is responsible for completing the follow-up and interventions report.

1. Providers must immediately take steps necessary to protect the waiver member's health, safety and welfare upon witnessing or discovering an incident.
2. The provider will immediately notify:
    a. The individual's guardian and/or next of kin, as legally appropriate:

i. Notification of incident with a severity ranking of 3 and above shall occur within two (2) hours.
ii. Notification of all other incidents shall occur within twenty-four (24) hours.

b. If the event occurred in an unlicensed facility/agency, Law enforcement and Adult Protective Services in instances of suspected abuse, neglect and/or exploitation of the member.
c. If the event occurred in a licensed facility/agency, Law enforcement, Healthcare Facilities Regulation Division, and the Long-term Care Ombudsman in instances of suspected abuse, neglect and/or exploitation of the member.
d. If instances of suspected abuse, neglect and/or exploitation of a member who is a minor, Law enforcement and the Child Protective Services.

3. The provider will submit the Incident Report electronically via the webform located at: [https://medicaid.georgia.gov/ under Provider links] or https://medicaid.georgia.gov/programs/all-programs/waiver-programs/hcbs-incident-reporting-system
within twenty-four (24) hours of the incident, or the discovery of the incident, but no later than one (1) business day if the incident occurred after business hours or on a weekend or holiday.
4. A confirmation email with a summary of the incident will be sent to the reporting provider, the contact person identified, and the member's case manager if they are not the reporting provider.
5. In all cases of suspected abuse, neglect or exploitation follow-up on referrals to law enforcement and regulatory authorities until resolution.

Follow-Up and Intervention Reporting

Used to provide additional information learned about the reported incident and to describe actions taken to resolve the incident and action steps taken to reduce or prevent the reoccurrence of the incident.

In collaboration with the appropriate providers, the case manager submits the follow-up and interventions report electronically via the link provided in the confirmation email within seven (7) business days of submission of the Incident Report.

a. Investigate the cause of the incident
    i. Ensure that no other incidents or abuse takes place while the investigation is ongoing.
    ii. Determine if risk factors existed prior to the incident, which may have identified potential for incident occurrence.
    iii. Identify interventions to reduce or prevent a similar incident in the future.
    iv. Identify the individual responsible for implementation of the interventions and the process for evaluating the effectiveness of the plan.

b. DCH will confirm within seven (7) business days if the interventions identified are acceptable and provide on-going monitoring until completion of the identified activities.
    i. If the interventions and/or corrective action are deemed to require modification, the provider will have three business days to resubmit the agency's plan to address the deficiencies cited in the follow-up and interventions report.

c. Intervention Types include, but not limited to:
    i. Staff related – staff training, review, changes to staffing patterns, or supervision
    ii. Individual related – review of protocols, new/additional assessments (behavioral or medical), coordination of care, review of service plan, increased observation
    iii. Equipment/Supplies related – purchase or repair equipment or supplies, obtain new devices
    iv. Environment related – evaluate the area, make physical modifications for mobility or safety, temporary or permanent relocation
    v. Policy and Procedure related – review or update written provider policies, procedures, and/or guidelines
    vi. Provider Quality Improvement related – internal investigation, internal corrective action plan, systematic assessment or change
    vii. Referral to other agencies or community services
    viii. Other – any action not identified above

d. Participate in regulatory agency investigations, if applicable

e. In all cases of suspected abuse, neglect or exploitation follow-up on referrals to law enforcement and regulatory authorities until resolution.

f. Maintain documentation of all reports and associated documentation in the client record.

1834 – DOCUMENTATION

POLICY STATEMENT

The Case Management documents in case notes all program activity related to a client.

POLICY BASICS

Each AAA may determine the format for organizing case records but the format should be uniform within the PSA and ensures that:

- Case notes are not shared with other agencies without written consent.
- Closed case records are retained for six years after closure.
- Case records are confidential.

PROCEDURES

Use the following procedures for documentation of new admissions:

1. Complete an initial summary for each client using case notes in the electronic data system. Describe the situation and explain how the care plan goals and objectives will be met.

2. Include documentation of the following activities in case notes:

- discussion with a client regarding the right to appeal

- discussion with a client regarding the potential for cost share (PMAO and MAO only), if applicable including estimated cost share

- discussion with client and/or care giver regarding his or her responsibility to apply for Medicaid benefits, if necessary (PMAO and MAO only)

3. Include any documents with original signatures and any documents not contained in the electronic client record in the client case record, including Power of Attorney and Guardianship documentation provided by the client and/or caregiver.

Documents which require original signature(s) include but are not limited to the following:

- original LOC and Placement Instrument

- copy of the Notice of Right to Appeal decisions regarding EDWP, Form 5381

- copy of the Authorization for Release of Information and Informed Consent

- copy of the Client Rights and Responsibilities Form

- original Potential Traditional/ Enhanced EDWP MAO Financial Worksheet, which contains client signed Statement of Intent: Cost Responsibility (PMAO and MAO clients only), if applicable other appropriate medical information

- EDWP Communicator, Form 5590 (PMAO and MAO clients only)

- EDWP Notification Form, Form 6500

- a copy of Traditional/ Enhanced EDWP Services Program Participation Form, Form 5389

- any other information appropriate to the case, (including but not limited to: Authorization for Release of Information, Form 5459/Release of Information, advanced assessments that are not in the electronic data system, CD-PSS training and participation documents and payment print outs- Financial Intermediary payroll statements etc.)

NOTE: A completed form in the electronic case record serves as documentation that the Case Management received or completed it.

4. Document the following items in the case notes in order of occurrence for applicants and active clients:

- communication with provider(s) regarding a client
- communication with a client/client representative/caregiver, including home visits and telephone contacts
- follow-up activities including referrals to other agencies, problem identification and resolution, case conferences and other related activities through use of the electronic data system

- significant information necessary for completing a CCP review
- reasons for any changes
- case conferences
- transfer information
- termination information
- significant information regarding changes in client condition, environment, support system, hospitalizations, or other issues

NOTE: Do not share case notes with other agencies or persons other than the client unless the client gives written permission.

EXCEPTION: The Office of State Administrative Hearings may request any part of a case record to assist with a hearing decision.

5. Document the following in CCP Review for active clients:

- feedback from client regarding services and client satisfaction in the Comprehensive Care Plan/Evaluation assessment sections in the electronic data system

- information regarding changes in the frequency or delivery of the services required or requested by client on the Service Order Screen

- recommendations for continued services if client's needs are sufficiently met on the Comprehensive Care Plan Screen or in Formal Case Notes

- coordination of other services not provided by the Traditional/ Enhanced EDWP on the Referral and Support assessment in the electronic data system

- comments regarding changes in client home environment on the Comprehensive Care Plan Screen or in Formal Case Notes

- changes in client physical status with use of drop down list on the Comprehensive Care Plan Screen
- changes in client informal support network on the Comprehensive Care Plan Screen and update the Contact Screen

- verification of client emergency contact person on the Contact Screen

- changes in emotional or mental status in Case Notes

- comments regarding problems or concerns the Case Management identified during the last care plan review in the Comprehensive Care Plan/Evaluation Screen and complete Complaint Screen as appropriate.

- follow-up activities in Case Notes (documentation of care plan screens will be pulled to formal case notes)

- coordination of emergency back up plans (state and informal) for Consumer Direction Option of Personal Support Services
- recommendations for other needed services and plans for securing them in the electronic data system or Referral and Support assessment if non-Medicaid
- information from providers pertinent to the client CCP review in Case Notes
- changes in the client's physician or medications on the Medication List
- changes in goals and/or interventions in CAPs

1835 – HELP AND DEADLINES

POLICY STATEMENT

Case Management and providers first contact the AAA which is the lead agency to discuss problems or questions about the EDWP/ Traditional and Enhanced.

PROCEDURES

Chart 1835.1 below indicates whom to ask for assistance:

CHART 1835.1 WHOM TO ASK FOR HELP

IF YOUR QUESTION IS ABOUT ...	AND YOU ARE A...	THEN ASK THE...
Traditional/ Enhanced EDWP	Case Management	Local AAA
Traditional/ Enhanced EDWP	AAA	Department of Community Health (404) 656-4507
Traditional/ Enhanced EDWP	Medicaid provider	Primary AAA
Traditional/ Enhanced EDWP Subsystem	Case Management	AAA
Traditional/ Enhanced EDWP Subsystem	AAA	DCH Help Desk 1-800-764-1017
Traditional/ Enhanced EDWP Enrollment Process	Medicaid provider	Department of Community Health, EDWP Section (404) 657-1999

Enrollment approvals	Medicaid provider	Department of Community Health (404) 656-4507
Reimbursements and claims	Medicaid provider	Billing Inquiry Unit, DMA (404) 657-9324
Reimbursements and claims	HP- a Billing Inquiry Unit member	Waivered Services Unit, DMA (404) 657-9324

1836 – STANDARDS OF PROMPTNESS

SUMMARY STATEMENT

Case Management completes EDWP activities within the standards of promptness guidelines determined by the Department of Community Health and DMA.

BASIC CONSIDERATIONS

Case Management, intake and screening, are required to perform all case management activities within the designated time frame according to waiver and policy requirements. The Department of Community Health/ Traditional/ Enhanced EDWP and the AAA monitor these activities through the electronic data system and individual case monitoring.

PROCEDURES

The following Chart 1836.1 gives the program standards of promptness:

CHART 1836.1 – STANDARDS OF PROMPTNESS FOR CASE MANAGEMENT

IF	**THEN** Standard of Promptness is within:
Respond to single telephone inquiry from member/applicant regarding Traditional/ Enhanced EDWP service	24 hours after telephone inquiry
Screen/Complete a single (phone/fax/web) referral from member applicant/family	Screening will occur within five (5) business days of referral and be completed within 15 business days after receiving the referral.
Re-screen waitlisted clients	Within 120 days
Notify client/caregiver of client denial/ineligibility after telephone screening	Immediately/during screening call
Lead CM/Nurse receives initial referral from the ADRC	2 business days to add the Nurse name in the electronic data system with 'refer for assessment' as the status. If referral received after 1pm, this is considered as received the following business day.

RN/LPN/Lead CM contacts member regarding initial assessment appointment	5 business days after receiving referral from Lead Care Coordinator in the electronic data system with 'refer for assessment' as the status
RN/LPN completes initial home visit	15 business days after Lead adds the Nurse in the electronic data system with 'refer for assessment' as the status **(based on risk and urgent need of the applicant- those at high risk/urgent need are to be assessed first)**
RN/LPN completes MDS HC- 9 documentation (initial or annual)	5 business days after face-to-face assessment visit NOTE: five additional business days for upload to Alliant Health Solutions (AHS).
Advise applicant of denial during screening	Immediate verbal notice
Written notification to the applicant of non-entry into Traditional/ Enhanced EDWP due to ineligibility, i.e. financial ineligibility or ineligible for services	3 business days after screening completed
Determine initial/recertification level of care	Upon return of the LOC from the Physician or the agency's Medical Director. NOTE: LOC PA is valid for up to 365 days. Remind physician offices that services can't start until the return of the signed Level of Care and Placement Instrument. **NOTE:** RN assigns the LOC within 24 hours/next business day/ of receipt of the LOC page signed by the physician/Medical Director.

Begin level of care re-determination process	2 months before expiration of the level of care **NOTE:** May begin as early as 3 months prior to expiration of LOC.
Assign LOC at reassessment	Upon return of the LOC from the Physician or the agency's Medical Director. NOTE: LOC PA is valid for up to 365 days. Remind physician offices that services may be interrupted until the return of the signed Level of Care and Placement Instrument.
Service changes are needed for changing client care: complete the MD change of service letter + applicable performance of the EDWP Modified Reassessment for the following reasons: Emergency Significant change in client condition or situation Adding another skilled service Terminating a skilled service Adding non-skilled service Move to another PSA	 2 business days after visit request 5 business days after visit request 10 business days after visit request As needed 5 business days after visit request 5 business days if client needs a change in service
Complete reassessments when requested by: Legal Services Office Administrative Law Judge	 5 business days after visit request
Admit an emergency client	2 business days after referral received
Broker services for an emergency client	24 hours after LOC assigned

Broker services for a new client	5 business days after LOC assigned

Telephone follow-up with a client after service brokered to assess service compliance, client satisfaction	During monthly contact, either during home visit or by phone – no later than the month after service was brokered Applies to initial brokering and subsequent changes in services brokering- use the electronic data system to track date and add to CM Tickler
Send client a Participation Form 5389	3 business days after brokering services
Send referral packet to provider **NOTE:** Packets can be faxed or sent by secure electronic mail. The provider's SOP begins the day they receive.	24 hours of brokering services
Complete and return EDWP Notification Form, to provider	3 business days after receipt from provider
Upload Traditional/ Enhanced EDWP Communicator (CCC) and LOC to DFCS	Upon completion of all required documents needed for the Gateway system, no later than 10 business days from the RN LOC approval • Submit a timely application for pending EDWP medicaid members in the DFCS Gateway system to protect the first month of coverage needed, the month the initial MDS assessment is performed. If the LOC is pending an appeal decision or pending PCP approval, submit the application with an unsigned LOC. Upload the signed/approved LOC once received. Resubmit a new application each time a denial is received by DFCS, allowing for approval of retro months, avoiding a lapse in protection when approved. Example, if MDS assessment is performed in April, submit first application no later than July. If denied by dfcs, for reasons other than over resources, submit another application as soon as possible to prevent lapse in coverage.
Initial review of Comprehensive Care Plan	30 days of admission (LOC certification date)/'RN approval date' in the Electronic Data System's MDS.

Provide signed copy of the initial Service Order to client **NOTE:** Copies of a changed Service Order are provided to client	Within 30 days of client admission Within 10 business days of the change in services
Subsequent Comprehensive Care Plan reviews	Every three months, no later than COB of the last day of that month.

Client monthly contact	Documented phone contact every calendar month following the month of the initial MDS visit, within the assessment tab/monthly assessment when no visit is completed
Complete a new care plan that includes exact service orders using only standardized abbreviations ("No change" notation may not be used)	At care plan review time and when client services change
Send completed care plan to the service provider(s)	Emailed to all providers prior to COB on the day of current care plan expiration.
Notify Adult Protective Services (APS), local law enforcement and Department of Community Health (DCH) Section Manager (or designee) suspected abuse, neglect or exploitation **NOTE:** If the client is in an ALS, notify HFR and LTCO instead of APS	Reported within 24 hours or one (1) business day of the incident or discovery of the incident to the Department. Submit the Follow-Up and Interventions Report to the Department within seven (7) business days of submitting the Incident Report.
Communication between transferring case management to newly requested case management re client rebroker request	Member requesting a move from one case management to another will have the current agency call the new agency within 24 hours of the member request. The receiving agency has 24 hours to respond and accept.

'Traditional/ Enhanced EDWP to Traditional/ Enhanced EDWP ' Transfer In client is received	Perform home visit 5 business days after phone/email communication from sending area that includes Alliant Health Solutions (AHS) transfer form and the Level of Care and Placement Instrument
Documentation of transfer in client electronic record when client moves to another PSA	2 business days after notification of transfer
Transfer of hard copy client record when client moves to another PSA	5 business days after address change documentation has been entered into the electronic data system and transfer form has been uploaded to Alliant Health Solutions (AHS) .
Processing SSI loss to Gateway for EDWP Category	Upon receipt of file from the AAA to the electronic data system, upload the CCC and LOC to Gateway within 3 business days for liability determination. Utilize the signed LOC from the SOURCE site if member is leaving SOURCE and moving to CCSP.

1837 – BROKERING SERVICES

SUMMARY STATEMENT

Brokering, the process of arranging for providers to deliver Medicaid waivered services, will be conducted when admitting new clients or changing services for active clients in accordance with established guidelines. Services are brokered with the provider(s) chosen by the client. If the client does not have a provider preference, a client can select a provider from a list provided in the data base.

NOTE: Providers are added to the data base following approval for enrollment by the Department of Community Health (DCH). The data base includes provider agency name, service type and Planning and Service Area (PSA) by county/counties approved by DCH.

BASIC CONSIDERATIONS

The Department of Community Health notifies the AAA of each provider number issued to an enrolled provider. No Traditional/ Enhanced EDWP clients are referred for services to a Traditional/ Enhanced EDWP provider until the Case Management has received the provider's DMA provider number from the AAA. New providers are added into the electronic data system and will be added to the data base log.

Case Management and the AAA use an up-to-date list of enrolled providers and their contact persons. The Traditional/ Enhanced EDWP electronic data system provides a computerized list of enrolled providers for each planning and service area (PSA).

If a provider agency fails or declines to offer a service for which it has been approved, the AAA notifies the Department of Community Health immediately.

NOTE: All ALS-Family Model family home subcontractors must be registered with the Department of Community Health. Traditional/ Enhanced EDWP clients are placed only in approved ALS Family Model homes that appear on the Division's registration list, a copy of which can be generated at the Case Management and AAA levels.

PROCEDURES

Use the following steps to broker services when the client selects/chooses his or her Traditional/ Enhanced EDWP provider:

- Indicate the provider selection on the care plan service order
- Contact the provider to broker service(s) for a new or active client

If the provider fails to contact the Case Management or brokering designee within 24 hours to indicate that a face-to- face evaluation will be completed within three business days. Then, the CM will immediately (the next business day), broker service(s) with another provider.

If a provider agency is chosen by the client but cannot provide the service as needed; see the

following examples for procedures:

The client selected a provider but needs immediate (emergency) services and the provider chosen by the client cannot provide immediate services. The CM asks the client to choose an alternate provider.

OR

The CM is unable to contact the provider within the time frame necessary to begin service for client with emergency need. The CM must contact another provider agency immediately to get services started.

OR

The provider accepts the referral but does not provide services needed; ask the client to choose another provider

Use the following steps when the client ***does not*** choose a provider agency:

- Provide a list to the client with agencies serving that county of residence and have the client select a provider agency

- Contact the provider with the referral information

If the provider fails to contact the Case Management or brokering designee within 24 hours to indicate that a face-to- face evaluation will be completed within three business days. Then, the CM will immediately (the next business day), broker service(s) with another provider.

If the provider refuses the referral made by client choice, indicate the provider's reason for the refusal in formal notes and refer the client to the next provider that is chosen by the client.

NOTE: If a provider refuses a referral made by client choice, adverse action may be imposed if the agency fails to accept referrals without legitimate reasons.

NOTE: Newly enrolled Traditional/ Enhanced EDWP providers are added to the electronic data system.
In preparation for brokering services with a provider, review client medical and Medicaid status to:

- Confirm completeness and accuracy of medical information
- Check current Medicaid eligibility.

Before admitting a client to Case Management, review LOC page, MDS-HC, CCP, and attached information to:

- Become familiar with client needs before calling the client to discuss admission to Traditional/ Enhanced EDWP

- Discuss cost share estimates if client is MAO/PMAO.

Update the CCP with additional information. Discuss changes in the plan of care with the Case Management RN/LPN who completed the assessment to get approval. Document this communication/collaboration on the CCP, Comment Section.

Telephone the selected provider to:

- Order the specific services needed and their frequencies
- Explain that a referral packet is forthcoming
- Advise the provider of client's Medicaid eligibility and discuss estimated client cost share.

Immediately forward to providers the referral packets for new clients and reassessment forms or CCPs for active clients in order to:

- Expedite services to clients by using electronic mail and a secure website, faxing or delivering referral packets to the provider agency, or by having the provider agency pick them up, no later than 24 hours after brokering services.

If providers pick up referral packets in person, avoid leaving referral packets in mailboxes unattended while awaiting pickup by the provider agency.

NOTE: For a new admission, providers complete a client evaluation visit after they receive a referral packet. If the client is in an emergency situation, providers usually initiate service prior to receipt of the packet; however, the provider may request hand delivery of the packet before beginning services.

In the referral packet to traditional providers, including *Structured Family Care service type, include a copy of the following information:

- Copy of LOC page
- MDS interRAI (which includes CAPS and Don R)
- Client detail/demographics face sheet report
- Comprehensive Care Plan Review and Service Order report
- Service specific task list
- Discharge Plan and Emergency Disaster Plan assessment
- Medication report
- Copy of signed Authorization for Release of Information and Informed Consent (signature page)
- If client is MAO or PMAO, copy of the completed Potential Traditional/ Enhanced EDWP MAO Financial Worksheet, which contains client signed Statement of Intent: Cost Responsibility
- Copy of DCH Authorization of Release of Information, if applicable
- Any other relevant information, including:
    - psychological and psychiatric evaluations
    - applicable advanced assessments
    - information about client that the provider needs before completing an Traditional/ Enhanced EDWP Case Management

evaluation/assessment

* Refer to 1407.3 (3) and 1407.4 (2) of the CCSP and SOURCE Personal Support/Consumer Direction/Structured Family Care manual regarding Appendix D completion and submission to the SFC provider.

NOTE: Clients transferring from SOURCE to Traditional/ Enhanced / **EDWP** with an active LOC/PA from Alliant Health Solutions (AHS), will broker care with the SOURCE MDS and LOC page to the service providers along with an updated care plan from the Traditional/ Enhanced EDWP RN/LPN visit, ordering new services under Traditional/ Enhanced EDWP in the electronic data system. Attaching documents listed above, will complete the referral packet.

NOTE: Send the Client Referral Form-Home Delivered Meals form and Appendix C HDM policy manual form to the Traditional/ Enhanced EDWP HDM provider when brokering this service.

Send a copy of the following to providers who deliver services funded by the Older Americans Act, Social Services Block Grant, or other non-Title XIX sources:

- Copy of LOC page and CCP
- Copy of Authorization for Release of Information and Informed Consent, signed by client.

Some non-Medicaid providers may require additional information.

After brokering services for a new client, complete the Traditional/ Enhanced EDWP Services Program Participation, Form 5389, to notify client of admission to Traditional/ Enhanced EDWP. List name, contact person, and telephone number for each Traditional/ Enhanced EDWP provider who will be providing service. Send original to client and retain a copy for the case file.

In the case notes, document activities related to service arrangement and communications with client, family, and other service providers.

Use Chart 1837.2 to determine activities involved when responding to provider notifications of changes in client service or situation:

Chart 1837.2 Changes in Service Status for Active Clients	
IF	**THEN**
Provider sends 30-day discharge notice to a client and client is still in need of service	Within three business days, contact client to discuss brokering services with another provider Advise new provider of the client's discharge from the previous provider. **NOTE:** Client does not appeal with Legal Services Office (LSO) if a provider sends a 30-day discharge notice to the client.
Provider notifies Case Management of a change in client status (hospitalization, change of address, death, etc.)	Within 24 hours, contact other providers involved in client care. Monitor client hospital stay to determine if reevaluation of service is needed upon discharge. Complete online incident report within 24 hours of notification.

1838 – BROKERING SERVICES FOR MAO/PMAO CLIENTS

POLICY STATEMENT

Clients not otherwise eligible for Medicaid may qualify for the Traditional/ Enhanced EDWP (Elderly and Disabled Waiver) class of medical assistance through the Medicaid waiver.

POLICY BASICS

When brokering service with a provider, the Case Management advises provider of client Medicaid eligibility status-SSI Medicaid, MAO, or PMAO-and discusses estimated cost share, if applicable. SSI Medicaid clients are not required to pay toward the cost of their Traditional/ Enhanced EDWP services, while MAO and PMAO clients are subject to cost shares.

At initial assessments, Case Management RN/LPNs advise MAO and PMAO clients of their estimated cost shares and include amounts on PMAO Financial Worksheets and Cost Share Brochure.

During the brokering of services, Case Management reviews the Medicaid eligibility process with PMAO clients.

PROCEDURES

1. Follow procedures indicated in Section 710.

2. Use procedures in Chart 712.1 below for brokering and authorizing services for MAO and PMAO clients:

Chart 1838.1 – BROKERING MAO/ PMAO CLIENTS

IF	THEN
Client has a Medicaid card NOTE: Verify Medicaid eligibility at Georgia MMIS Web Portal, http://www.mmis.georgia.gov/portal , or contact DFCS to verify Medicaid eligibility and class of assistance.	Client may be currently Medicaid eligible. Medicaid recipients receive cards with a 12-digit number. These Medicaid numbers do not identify the Medicaid class of assistance.

Client is eligible for a category of Medicaid other than SSI Medicaid	1. Remind the client of cost share responsibility. Explain to clients that failing to pay cost share may put them at risk of losing services. 2. Send a copy of the PMAO Financial Worksheet to the provider with the referral packet or fax the information when possible. 3. Send the CCC, LOC page and copy of MAO Worksheet to DFCS.
Client is potentially Medicaid eligible	1. Follow steps 1-3 above. 2. Remind client/representative of the Medicaid eligibility process. 3. When sending the CCC and LOC page to DFCS, advise the client to apply for Medicaid. **NOTE**: If the Case Management sends the Medicaid application with the CCC and LOC page. Ensure client understanding of mandatory telephone interview and verification processes required for Medicaid eligibility. 4. Within two weeks of sending the referral and/or application to DFCS, communicate with the client to determine the Medicaid application date and if the client has been interviewed. Communicate with DFCS within 30 days for additional needed interventions and resubmission of initial paperwork if needed. **NOTE:** The application date is the date DFCS receives the Medicaid application.

	5. Make a good faith effort to ensure that the client is proceeding with the Medicaid eligibility process. If the client is having difficulty with the Medicaid process, schedule a case conference to determine ways of providing assistance. 6. If no communicator, notice of eligibility or cost share determination letter (if applicable) is received 45 days of the Medicaid application date, contact Regional/District DFCS staff person via escalation process, to determine the client's eligibility status. **NOTE:** If the client's Medicaid application is not processed within 45 days, contact DFCS via escalation to District contacts frequently until eligibility is established.

1839 – BROKERING EMERGENCY

ADMISSIONS POLICY STATEMENT

Emergency admissions to Traditional/ Enhanced EDWP must meet the same eligibility requirements imposed on all other Traditional/ Enhanced EDWP admissions and have the highest DON-R score. Emergency cases are determined on a case by case basis and placed into service immediately, after physician or the agency's Medical Director signature has been received.

POLICY BASICS

The AAA and Case Management work closely together to determine if a client is an emergency case. Referral is sent immediately to Case Management for initial assessment.

PROCEDURES

Complete all assessment activities before brokering emergency services. Use the following procedures to begin emergency brokering of services:

1. telephone the appropriate service provider to obtain a tentative schedule for beginning services.

NOTE: If unable to reach provider to broker within time frame necessary to begin service, immediately contact another service provider.

2. fax or send, via secure electronic mail the referral package to the provider as quickly as possible.
3. contact the referral source, client and/or family to give the schedule for services to begin.
4. within one week, follow up with client and/or family to confirm that the provider is delivering services as scheduled on the EDWP Notification Form and as ordered on the CCP.
5. provide ongoing Case Management services after arranging for services for emergency cases.
6. assure that the AAA has client name, date of admission to the program, and Medicaid number for the log of emergency admissions.
7. conduct all the activities required for other clients admitted to Traditional/ Enhanced EDWP on a non-emergency basis.

1840 – AUTHORIZING BROKERED SERVICES

SUMMARY STATEMENT

Authorization for provision of Traditional/ Enhanced EDWP services to clients and Medicaid reimbursement to providers is delegated to Case Management.

BASIC CONSIDERATIONS

Case Management uses the Service Authorization Form (SAF) to authorize services. The SAF is used to manage Traditional/ Enhanced EDWP costs at both the regional (PSA) and state levels and:

- Informs DMA of approved procedures and maximum allowable dollar amounts/services provided. HP and DMA match SAF information to provider claims before issuing payments.
- Establish each client's Traditional/ Enhanced EDWP anniversary date through the Services Begin Date, the date the client received the first waivered service reimbursed by Medicaid.

Before the Case Management authorizes services, a client must have a valid Medicaid number and be registered in the electronic data system. The electronic data system completes the authorization process electronically.

PROCEDURES

1. Provider completes the initial face to face evaluation of the client's condition within three business days of receiving the referral packet from the Case Management.

2. Provider begins client services within 48 hours from the face-to-face evaluation.

3. Once services begin, the provider RN/LPN sends the Case Management a EDWP Notification Form within three business days. The EDWP Notification Form reflects the date services began and frequency of services ordered.

NOTE: If Case Management does not receive EDWP Notification Forms within three days of the face-to-face evaluation by providers, contact providers to request the EDWP Notification Forms and authorize Traditional/ Enhanced EDWP services.

4. CM responds to the provider EDWP Notification Form and generates an SAF within three business days **if** the client has an active Medicaid number (Q-Track and Family Medicaid excluded).

NOTE: If the client does not have active Medicaid eligibility [Potential Medicaid Assistance Only (PMAO) or Medicaid Assistance Only (MAO)], the CM assists the client with the Medicaid application process and uses the following procedures once the eligibility process is complete and the Medicaid number and cost share, if applicable, has been received from Division of Family and Children Services (DFCS).

In the* electronic data system*, CM enters estimated cost share in the Service Order section. When the actual cost share amount is received from DFCS via the Traditional/ Enhanced EDWP Communicator (CCC) or other "written" documentation, the CM adjusts the liability in the electronic data system, both the service order and saf tabs. The cost share assigned by DFCS should only be reconciled in the client's favor back to the month the assigned provider(s) began collecting the estimated cost share, which should begin with the month services begin after they meet LOC and all parties sign the Level of Care and Placement Instrument.

The* CM *sends the corrected SAF to the provider within three business days and communicates the need for the provider agency to adjust any claims which may have been submitted prior to the date of this SAF update

If the actual cost share and the estimated cost share amount matches; then, the* CM *documents the information in notes and does not generate a new SAF(s).

CM sends a copy of the ***initial*** SAF and any subsequent SAF which reflect a change, to the provider agency/agencies.

Providers can access current units and cost share through the Medicaid Management Information System portal.

Chart 1840.1 – RESPONDING TO INITIAL EDWP Notification Form

IF	THEN
After provider's initial evaluation, the provider requests change in service	Within three business days, return EDWP Notification Form advising provider of approval or disapproval of request for change in service.
Services and frequency indicated on the provider's initial EDWP Notification Form are the same as listed on CCP	Sign and date EDWP Notification Form to indicate receipt of the provider's verification of service delivery. AND Within three working days, return a copy of the EDWP Notification Form to provider. File original in case file.
Services and frequency on provider's initial EDWP Notification Form do not agree with CCP AND Case Management does not agree with provider's service delivery	Call the provider to clarify service order. Indicate reasons for denying provider's request for change in service on EDWP Notification Form. Within three working days, sign the EDWP Notification Form and return it to provider. If necessary, broker services with another provider.

Determine if the client received Traditional/ Enhanced EDWP services in the past. If so, reactivate old client case file.

Send subsequent SAFs to providers at least five working days prior to the month for which services are authorized.

Use procedures in Chart 1840.2 to authorize home health visits.

Chart 1840.2 - Authorizing Home Health

Client has received less than 50 Medicaid home health visits	Do not enter the Medicaid Home Health provider on the SAF
Client has received 50 Medicaid home health visits but needs additional	Enter the HDS provider on the SAF for the 51st and subsequent home health visits provided during the remainder of the calendar year **NOTE:** Clients may receive the first 50 visits from a home health agency not enrolled in Traditional/ Enhanced EDWP.

1841 – DISCHARGE PLANNING

POLICY STATEMENT

Discharge planning is instituted at the beginning of Traditional/Enhanced EDWP participation to assist a client in making the transition from one service environment to another.

Each client admitted to the program has a discharge plan to facilitate transition from one Traditional/ Enhanced EDWP service to another, or from the Traditional/ Enhanced EDWP to another service setting. Discharge planning is conducted to:

- Plan for continuity of an individual's health care
- Maintain the individual's level of functioning
- Lower an individual's readmission rates to medical facilities.

Discharge planning involves a client's support system and individuals from various disciplines working together to facilitate the transition. In addition to the Case Management and Traditional/ Enhanced EDWP provider, those involved in discharge planning may include, but are not limited to the following:

- Family members and other informal support

- DFCS
- Personal Care Homes/Nursing homes
- Department of Behavioral Health and Developmental Disabilities
- Long Term Care Ombudsman
- APS
- Other agencies serving a client.

Case Management must maintain a coordinated program of discharge planning to ensure that clients have planned programs of continuing care which meet their post-discharge needs.

The Traditional/ Enhanced EDWP provider and Case Management collaborate regarding the status of a client and the discharge planning process for that client. Refer to Part II, Chapters 600-1000, Traditional/ EDWP General Services manual, Chapter 600, Section 606.1.

EXCEPTION: ERS and HDM providers are not required to develop discharge plans.

PROCEDURES

Complete the following activities for discharge planning:

- Develop the discharge plan during the initial assessment and at each subsequent care plan review using the discharge planning checklist located at https://www.mmis.georgia.gov/portal/default.aspx and in the assessments tab.
- Reflect a summary of the discharge plan in care plans
- Coordinate discharge planning in consultation with the provider's RN/LPN, other provider staff, the client's physician or the agency's Medical Director., other involved service agencies, and other local resources available to assist in the development and implementation of the individual's discharge plan.

Consider the following factors:

- Problem identification, anticipated progress
- Evaluation of progress to date
- Target date for discharge (difficult to assess)
- Identification of alternative resources for care after discharge.

Use the following procedures for discharge planning:

1. Maintain a close working relationship with the Traditional/ Enhanced EDWP provider. This is especially important when a client discharge situation is complicated and problematic and the

   provider determines that no appropriate resources are available to meet client needs.

2. Coordinate a case conference with all appropriate agencies and individuals involved when a client appears to have no satisfactory discharge plan.

   - Participants at the case conference assure that a client is not discharged from services without appropriate care or placement.

   - All agencies involved share a responsibility and role in discharge planning for clients they serve or will potentially serve and are represented at the case conference.

3. Coordinate with DBHDD care management regarding discharges for clients who have secondary mental health or mental retardation diagnoses.

4. Record changes/updates on the discharge planning checklist and the CCP.

5. Prior to discharge implementation from Traditional/ Enhanced EDWP, Case Management, physician or the agency's Medical Director., client/representative and provider collaboration will occur to follow the current discharge plan checklist designed by all parties that follows the preferences of the care requested by the client/representative.

NOTE: Provide the discharge plan to the appropriate parties, upon request, at a hearing conducted by an Administrative Law Judge (ALJ) from the Office of State Administrative Hearings (OSAH) on an adverse action decision made by the Case Management, Alliant, or utilization review (UR). For a member denied at initial assessment, provide contact information on the AAA/ADRC based on the region where the member resides. https://www.georgiaadrc.com/site/363/contact_us.aspx

1842 – COMPREHENSIVE CARE PLAN REVIEW

SUMMARY STATEMENT

Case Management conducts quarterly, formal, in-home visit reviews of each Traditional/ Enhanced EDWP client's Comprehensive Care Plan according to an established schedule and maintains monthly phone contact during months that no face-to-face visits occur. Documentation occurs in formal notes, note type should equal "monthly client contact" as well as in the assessment tab, monthly contact assessment type.

NOTE:

EDWP applicant screening performed by Case Management for SOURCE and the Area Agency on Aging for CCSP as well as monthly contact call policy requirements for Case Managment are to

utilize a camera telehealth modality encrypted (end to end encryption) software product with established business agreement that protects PHI (protected health information). PHI is information about health status, provision of health care, or payment for health care that is created or collected by a covered entity and can be linked to a specific individual. Applicant/member or AAA/Case Management with access to landline phone (one way) can be utilized in place of the software requirement. Landline/non internet use is appropriate (copper wires that carry their own power and work during blackouts). Follow up calls not involving billable service work requires I phone or Android encryption cell settings use or landline. Use of electronic health records, member portal access or app use are to be encrypted (end to end encryption) with business agreement as well.

BASIC CONSIDERATIONS

The Case Management completes the first formal review of each Traditional/ Enhanced EDWP client's Comprehensive Care Plan (CCP) within 30 days of the Level of Care (LOC) certification date/RN approval date within the MDS. After the 30- day review, Case Management completes CCP reviews as needed but no less frequently than every three months.

NOTE: If the three month review visit sequence is interrupted with a required EDWP Modified Reassessment by the nurse staff, the next due three month review visit should be three months from the date of the EDWP Modified Reassessment, prior to the end of day on the last day of the month.

NOTE: If member is a transfer from the same Case Management agency, A home visit by the new/receiving agency is also not needed as it is the same agency, just a different office belonging to that agency. Both offices will coordinate care should new service providers need ordered and services/frequency changes need to take place. A new planned service and new PA/SAF will need to be set up for the receiving agency in the electronic data system. A transfer form will need to be sent to Alliant for the purpose of the LOC PA transfer. See 1851/Transfers.

NOTE: Send the Modified Reassessment to the provider(s) noting the next due date, which matches the manually adjusted 'next due' care plan review assessment date. Send applicable signed Physician letter to the appropriate provider.

The Case Management develops the care plan, involving the client in decisions to the extent possible. The CCP identifies the client's needs, goals and interventions used by the agency or person responsible for providing services.

At each CCP review/MDS/Modified assessment, Case Management uses the electronic data system and/or the online incident reporting system to complete/update the following:

1. Care Plan Review including risks/goals and task lists (changed tasks only or upon request by service provider) (care plan review assessment not applicable if the Modified assessment is performed)
2. Service Order updates if applicable
3. Service specific evaluations
4. Medication/Diagnosis List updates
5. Case Notes
6. Applicable advanced assessments
7. Discharge planning and Emergency Preparedness documents/assessments

8. Complaint log/ Case Conference assessments if applicable

NOTE: As of 4/1/2020, refer to Part II Chapters 600-100 Policies and Procedures for CCSP and SOURCE General Services Manual, 601.6 for reporting of incidents such as ER and hospitalizations in the new online reporting system.

9. Referral and Support tracking assessment and contact tab updates

At each CCP review/MDS/Modified assessment, Case Management uses forms to complete the following:

1. Authorization for Release of Information and Informed Consent (signature page)
2. Nutritional Screening Initiative Checklist, if applicable
3. Client Referral Form-Home Delivered Meals and Appendix C HDM policy manual form, if applicable

At each care plan review, the Case Management generates, from the electronic data system, any documents which require an original signature.
CM obtains signature(s)/signs, sends copies to providers as appropriate and files signed documents in the case record.

There is no grace period beyond the CCP due date. CCP reviews completed past the quarterly due date are out of compliance. If the due date for the next CCP review falls on a weekend or holiday, the Case Management completes the quarterly review before the due date. Intervening weekends or holidays do not change the CCP review due date.
If a client is unavailable to complete the CCP review because of hospitalization, a visit out of town, or for another reason, Case Management documents attempts to complete the CCP review in a timely manner in the case notes. Note the reason for delay on the service order, and send this information to the provider at CCP review. Complete the CCP review as soon as possible.

The Case Management may conduct CCP reviews before the required care plan review date, but completes CCP reviews no later than the scheduled due date.

EXAMPLE: On January 05, 2019, the Case Management admits (certifies the LOC) the client to Traditional/ Enhanced EDWP and brokers service(s). The first CCP review is due by February 04, 2019, and the second CCP review no later than May 31, 2019.

Subsequent CCP reviews are due at a minimum of every three months, by the last day of the month.

PROCEDURES

STEP 1 Use the following procedures to complete each CCP review Prepare for the CCP review as follows:

- Review the case file to become familiar with client situation at the time of the last contact
- Note any item which needs updating during the CCP review

- Assure that client LOC is current

STEP 2 Telephone the client to schedule a home visit to conduct CCP review

STEP 3 During the home visit, use the electronic data system to update current or complete new care plan review, Service Order, Evaluations, Task lists, Medication List, Disaster Plan and other applicable assessments.

- Document changes in client's physician or medications on the Medication List

STEP 4 Address additional triggers and evaluate goals indicated on the previous CCP

to:

- Assure that services ordered remain appropriate
- Determine client need for continue Traditional/ Enhanced EDWP services

STEP 5 Review services that care giver or others provide

STEP 6 Identify any new services a client may be receiving from the community. Include all services on the Service Order

STEP 7 Determine how frequently providers are delivering services indicated on the Service Order. Use the care plan evaluation screen to document whether client is satisfied with services being provided

STEP 8 Use the care plan evaluation screen to document compliance and satisfaction for clients who receive ALS and/or ADH. At a minimum, review the following in the clinical record:

- RN Supervisory notes
- Progress notes
- Documentation of any additional services being rendered
- Hospital admission Notes Step 8, if applicable
- Medication list and prescription label instructions.

Discuss concerns about non-compliance with client care and /or physical environment with the Lead Case Management and/or the assigned Case Management and Provider Specialist.

STEP 9 Discuss with client and/or the care giver any changes in problems/variances, interventions, and goals. Document change on the care plan review assessment.

STEP 10 If the member experiences a change in condition and the current level of care is less than 270 days, during the 365 days of a length of stay that requires a change

in level of service or the addition of a new service that requires a physician's order, a full reassessment is not required. The nurse must make a face-to-face assessment of that condition, update the case notes and service order, and request a physician's order using the change of service letter + performance of the EDWP Modified Reassessment to cover the new service for the remainder of the length of stay. Examples:

1. Needed service category is a skilled service

2. Change in Adult Day Health (ADH) level

3. Change in Case Management level (TCM to ECM only)

4. Change from one service category to another

   (Moving from PSS/X to either Consumer Direct Cd Pss or Structured Family Care SFC requires only the completion of the physician's change of service letter.) A recommended Modified assessment can be completed on a SFC applicant in order to determine a recent decline of the member that currently does not receive a daily 5 hour assessed need. Telehealth Modified is permitted to add ERS to current approved LOC.

5. Member enters a facility that requires a LOC on a DMA-6 and seeks re-admission to Traditional/ Enhanced EDWP and a change in services is required

6. Member transfers from Source to CCSP and to a different case management or CCSP to CCSP and to a different case management and a change in service is needed

7. Member has significant injury/illness requiring service additions

- NOTE: RN Case Management staff consult with Provider RN/LPN from PSS/PSSX/ALS/ADH and RN/SNS for ECM/TCM reevaluation and Nursing Supervisory Visit form/Appendix DD (for applicable services) for *ECM* and *Defining ECM form* completion.

NOTE: Remind physician offices that services can't start until the return of the signed change of service letter.

STEP 11 Access current CCP in the electronic data system, complete the change of service letter + performance of the EDWP Modified Reassessment and send to the client's physician or the agency's Medical Director. When approved (by signature of physician or the agency's Medical Director., nurse practitioner or physician assistant) is received, file the change of service letter in the client's case records.

NOTE: ADH therapies, HDS and SNS (skilled services) additions require physician orders before specific medical procedures can be provided. Orders for therapy services must include specific procedure and modalities used frequency and duration of services.

STEP 12 Document the reason for the change (s) in the comment section of the CCP or the service order and adjust the service order date to reflect the day the change in service was completed. If additional documentation is needed, then document in case notes

STEP 13 Send copies of the revised Service Order, EDWP Modified reassessment and cover letter with physician or the agency's Medical Director. (PA or RNP) signature and revised SAFs to the provider (s)

NOTE: Use the CCC to notify DFCS that the client continues to receive a waivered service when changes are the result of client's return from a facility requiring a DMA-6 for admission. Attach the most recent Level of Care and Placement Instrument with existing length of stay.

STEP 14 If the member experiences a status change and the current level of care is less than 270 days, during the 365 days of a length of stay that requires no change of services, a full reassessment is not required and the nurse must make a face to face assessment of that condition/change and update the case notes and care plan. Examples:

1. New member does not receive any waivered service within two months (60 days) of the date Alliant Health Solutions (AHS) validated LOC or existing member does not receive service for 60 days

2. Member has significant injury/illness requiring service frequency changes

NOTE: Changes in existing chronic conditions or exacerbation with no DMA-6 use, caregiver changes, and client transfers from one AAA to another will not require a visit by the RN/LPN with the completion of the change of service letter when there are not service additions needed. The RN/LPN must clearly document the stability of the condition for those returning without the DMA-6 completion

NOTE: Because the existing LOC PA is valid for up to 365 days, a provider can resume care for all services noted on line 23 of the current Level of Care and Placement Instrument upon client discharge from nursing home/rehabilitation facility and/or hospitalization while awaiting communication from Case Management about possible service changes/additions that may follow. A physician or the agency's Medical Director order using the change of service letter is required for any service additions that differ from care received prior to the nursing home stay.

NOTE: If the existing care plan expired while the client was in a facility, the Case Management agency must make a face-to- face assessment of that condition/change and update the care plan

PRIOR to the provider resuming care on the existing Level of Care.

NOTE: If a member needs a change in service within 60 days from the date the RN approves/signs the LOC, the Case Management will document and date the added services on the Service Order and applicable Modified and Comprehensive Care Plan and provide a copy to the member's physician or the agency's Medical Director. and the service provider (s). No face to face visit or physician letter is required in the situation unless the client is returning to the community from a nursing/rehabilitation facility.

NOTE: If the care plan and new Level of Care remain at Alliant Health Solutions (AHS) for approval and the current care plan expires, send the pending care plan to the agencies who have existing care in place. Any new services need the approval of the Level of Care by Alliant Health Solutions (AHS) and the physician or the agency's Medical Director.. The new services would not be brokered and sent until the Level of Care is approved. The existing services are using the current level of care to continue providing services. The pending Level of Care will not begin until the existing one expires.

The pending care plan will not have a certified through date on the new care plan until the Level of Care is locked.

NOTE: All face-to-face assessments noted above that are performed by an LPN requires documentation of collaboration with RN staff in case notes documenting a review of work performed by the LPN.

NOTE: Minimum data element recommendations in formal notes are listed below when face-to-face assessments noted above are performed with the modified reassessment IF NOT ALREADY ADDRESSED IN THE ASSESSMENT.

- *Medication and new treatments review (IV/dialysis etc)*
- *Diagnosis that caused the admission*
- *Equipment changes (DME)*
- *Diet/skin condition changes*
- *IADL/ADL need changes-(updated task list)*
- *Changes in formal/informal support*
- *Additional teaching and training issues*
- *Changes in mobility/condition*
- *Next scheduled physician visit*
- *Review of waiver and non-waiver services in the home*
- *Admit/ discharge date re hospitalization and rehab stay*

STEP 15 Document verification or the client's response regarding eligibility or continued eligibility for Medicaid. If a client is PMAO, contact DFCS to determine the status of Medicaid application and document the information in case notes.

STEP 16 Obtain client signature on the Authorization of Information and Informed Consent during the home visit and remind the client to contact CM with concerns.

NOTE: At the 30- day review, discuss contents of Traditional/ Enhanced EDWP folder with the

client, if not discussed at the initial assessment. Provide the client/family member with contact information for Case Management.

STEP 17 Telephone CCP reviews are allowable only in extenuating circumstances, such as a Case Management vacancy. If such an Event occurs, the Case Management must first obtain a temporary waiver from the Department of Community Health, which will allow Case Management to conduct CCP reviews by telephone for a specified period of time. In the member notes tab/comments section of Service Order, document the reason that the CCP review was conducted by telephone instead of in person.

STEP 18 Send a copy of newly completed Care Plan, Service Order, signed Authorization of Information and Informed Consent form and any applicable task lists, updated medications and current advanced assessments to each provider.

NOTE: Send these copies to providers no later than three days prior to the due date of the CCP review

STEP 19 Update client information in the electronic data system. Include changes in address, living arrangements, diagnoses, and other information Generate and send SAFs authorizing providers to continue services, if applicable

STEP 20 Retain the new Care Plan, Service Order, Evaluation, and Medication List in the client's electronic file

1843 – FOLLOW-UP ACTIVITY

POLICY STATEMENT

Case Management conducts follow-up activities to monitor service delivery and the client's ongoing situation and progress.

POLICY BASICS

Follow-up requires effective personal, telephone, and written communication between the Case Management and client, the client's family and/or care givers, client's physician or the agency's Medical Director., service providers, and other Case Management team members.

Case Management documents all follow-up activities in the client's case notes. The EDWP Notification Form, used by providers to follow up on telephone calls to the Case Management regarding any changing in the client's situation, may be used as a tool to assist with follow-up activities.

Follow-up activities are necessary to:

- Confirm quality care is provided to eligible clients

- Assure that services rendered are appropriate, effective and provided as ordered on the CCPs, and as indicated on the EDWP Notification Form

- Identify any client complaints or concerns about services received or needed

- Determine if any changes in client situation require a change in services

- Identify death other than natural causes and report it to appropriate authorities in cases of serious injury or suspected abuse.

PROCEDURES (PMAO CLIENTS)

Use the following procedures for follow-up with PMAO clients to ensure that only eligible clients receive services:

1. Advise client when to make application with DFCS for Medicaid under the Traditional/ Enhanced EDWP class of assistance. Contact DFCS to obtain Medicaid application date.

2. Contact DFCS to determine the status of the Medicaid application until Medicaid eligibility is determined.

PROCEDURE (LEVEL OF CARE)

Use the following procedures to ensure that a client has a current LOC certification:

1. Establish a system for tracking LOC certifications
2. Begin the LOC redetermination at least 60-90 days prior to the expiration of the current LOC certification

3. After sending the LOC page and CCP Service Order to the physician or the agency's Medical Director., monitor its return to ensure receipt before the current LOC expires. In the case notes, document contacts with the physician, provider, family, and others regarding the return of the LOC page

4. Send DFCS a copy of the CCC and the LOC at initial certification and only the LOC at recertification

   NOTE: For CCC Section I, use CURRENT year RN/LPN visit date (initial MDS) on the CCC *case management service began effective* date. Do not send the CCC at recertification. Sending the LOC only is appropriate.

   If member is in the nursing home at the time of the initial assessment, Case Management is to

indicate the nursing home discharge date for retro approval processing of EDWP category of assistance back to the NH dc date and not the MDS visit date. If the member resides in a nursing home during the recert MDS or Modified assessment to resume EDWP care, indicate the nursing home discharge date when sending to DFCS for retroactive approval processing of EDWP category of assistance back to the NH dc date and not the MDS visit date.

5. Send copies of the new LOC certification and other reassessment documents to providers

Use the following procedures to provide follow up for a LOC denial or termination:

1. Use a CCC to notify DFCS of MAO client LOC denial or termination

2. Notify providers of client LOC denial or termination

3. If clients request, assist with appeals for denials and terminations of their LOC certifications

PROCEDURE (CHANGE IN SERVICES ON THE CCP SERVICE ORDER)

Use the following procedures to provide follow-up to ensure that services rendered are appropriate, effective, and provided as ordered

1. Document in the client's case notes all contacts with client and providers to ensure that authorized changes in service have occurred and are satisfactory

2. Request that providers and clients contact the Case Management regarding changes in client situation

3. Request that providers track the number of home health visits and notify the Case Management prior to the 50th visit Beginning with the 51st home health (HDS) visit, add the HDS to the SAFs

4. Respond on a timely basis to requests for changes in service units or service type on the SAF

PROCEDURES (MONITORING SERVICE DELIVERY)

Case Management is responsible for the documentation and follow up for all complaints and concerns about service delivery. Use the following procedures to monitor service delivery:

1. Within three business days, create the complaint screen in the electronic data system client record, associated with the complaint. Contact the provider to advise of the complaint or concern and request a response.

2. Document the provider's verbal response on the complaint log and, if appropriate, request

written response from the provider.

3. Follow-up, as appropriate, to ensure that the complaint/issue is satisfactorily resolved. If the provider does not respond or fails to satisfactorily resolve the issue, follow up with the provider again and send a written request to the DCH for assistance. Also, contact the client to report the disposition of the complaint/issue.

4. If attempts to resolve a problem are unsuccessful, the Case Management, using clear documentation may consult with DCH to request removal of the provider agency from the active provider list and notify the provider agency in writing of this determination. When removed from the active provider list, the provider agency may continue services to current clients. Case Management agencies will not refer or broker any new clients during the period the provider is removed from the active provider list. When the provider agency has corrected the deficiency, the provider must notify DCH and the Case Management in writing and DCH and the Case Management may reinstate the provider agency to the active provider list. The DCH will then notify the Case Management
5. In coordination with DCH, use the electronic data system Complaint Log report to analyze the data. Review data from complaint logs to determine trends and the need for further action. Complaint reports are accessed and reviewed by designated DCH staff member(s) and the Case Management manager by the 15th of each month to assure quality of provider services, identify provider compliance issues and intervene to improve client satisfaction and service delivery.

PROCEDURES (ISSUES IN QUESTION)

To ensure identified concerns are being handled or have been resolved and activities discussed have been initiated or completed, use the following procedures to provide follow-up:

1. Follow-up with clients, care givers, providers and others regarding the issues in question.

2. Link clients with appropriate resources to resolve problems, if needed.

PROCEDURES (ABUSE/NEGLECT)

Case Management and/or providers report immediately suspected mistreatment, neglect, abuse, or financial exploitation, and injuries of unknown source to Adult Protective Services (APS) Centralized Intake Unit. Follow-up on abuse reports within seven business days and document information in client record.

EXCEPTION: For ALS clients, report abuse to the DCH, Healthcare Facility Regulation Division, LTCO and APS.

Ensure interventions identified in response to a reported incident are monitored and effectively address risks to the member.

Report incidents of child abuse, neglect and exploitation of individuals 18 years of age or younger to DFCS Child Protective Services in the county where a client resides.

1844 – SERVICE SPECIFIC FOLLOW-UP ACTIVITIES

POLICY STATEMENT

Service specific follow-up activities are conducted according to the type of services ordered.

POLICY BASICS

Provider service manuals contain detailed information about each Traditional/ Enhanced EDWP service. Case Management should be familiar with information contained in provider manuals.

PROCEDURES

Report to the AAA any problems or concerns regarding a provider or facility.
Assure that clients are involved in care planning and treated with respect and dignity. Become

familiar with role of supervisory RN for all applicable services.

Use procedures in the Chart 1844.1 below when conducting follow-up and other Case Management activities related to the following specific services:

CHART 1844.1 – FOLLOW-UP ACTIVITIES RELATED TO SPECIFIC SERVICES

IF	THEN
Alternative Living Services (ALS)	Become familiar with Rules and Regulations for Personal Care Homes, Chapter 111-5-35 and the Policies and Procedures for Alternative Living Services (ALS) (Traditional/ EDWP). Talk with the home provider regarding client condition and care. **NOTE:** A client is permitted a trial visit from a private residence or a nursing facility to an ALS facility to determine the appropriateness of placement in the ALS home. The trial visit is limited to no more than 7 consecutive days. The ALS provider is entitled to bill for 7 consecutive days of a trial visit when recommended by the client's physician and authorized by the Case Management. Complete the ALS checklist. A reassessment is not necessary for the trial visit. The Case Management should complete an interim Comprehensive Care Plan (CCP) with the following information: • Add the trial visit to the CCP • Document in the comments section • Indicate the dates of the trial visit Send the revised CCP to the ALS provider. To allow Case Management to coordinate home health services, ALS providers inform Case Management when clients need or receive skilled services and/or therapies. When a client residing in an ALS setting is also participating in Adult Day Care services, interview the client to determine whether participation in the Adult Day Care program is ***voluntary***. Documentation must reflect that Adult Day Care participation is the client's choice. If participation is not voluntary, coordinate steps with provider and client to resolve the conflict to

client satisfaction.

IF	THEN
Adult Day Health (ADH)	Become familiar with Policies and Procedures for ADH Services (Traditional/ Enhanced EDWP). The ADH provider must provide two levels of care and the activities associated with each level. Visit ADH clients at least once a year at the ADH center. Speak with the provider regarding client condition and care. Complete the ADH checklist.
IF	**THEN**
Home Delivered Meals (HDM)	Become familiar with Policies and Procedures for HDM (Traditional/ Enhanced EDWP). Whenever possible, visit clients receiving HDMs at mealtime to examine the meals and discuss them with clients. At a minimum, examine the client's HDM bi-annually. In situations where meal delivery varies from daily delivery, document the Service Order with the delivery information. Emergency meals may be ordered twice per year. **NOTE:** Bulk deliveries will be annotated and include scheduled day of delivery. **Frozen or shelf stable meals that are delivered weekly are to be billed for the date they are expected to be consumed.** **EXAMPLE: Meals that are delivered for the 7-day week on Monday 10/1/12 must be billed for 10/1/12 through 10/7/12.)** A nursing modified assessment is not required to add HDM services.

IF	THEN
Home Delivered Services (HDS)	Become familiar with Policies and Procedures for Home Health Services and the Policies and Procedures for HDS (Traditional/ Enhanced EDWP). The HDS provider must provide skilled nursing and therapies and medical social work. At the beginning of each calendar year, ask the Medicaid Home Health/HDS provider to track the number of home health visits that a client receives. The provider may use the EDWP Notification Form to notify the Case Management of the anticipated date when the client will receive the 50th visit.
Emergency Response System (ERS)	Become familiar with Policies and Procedures for ERS (Traditional/ EDWP). Client (s) receiving ERS must test his/her unit one time per month to ensure the unit is working properly. If the client will be out of the home for any reason, notify the provider. Unlike other service providers, the ERS provider does not routinely visit clients in their homes. If a client's home is infested with common household pests, notify the provider so they may determine if this affects the ERS. Collaborate with the ERS provider in assisting members with reminders of monthly tests of the ERS transmitter device.

Personal Support Services (PSS)	Become familiar with Policies and Procedures for Personal Support Services Manual (Traditional/ EDWP). PSS and PSSX duties are the same. The difference between the two is the time required to perform the tasks ordered on the CCP. PSS is ordered for a minimum of two hours or eight (8) units per client. Exceptions to the two- hour minimum include: Client resides in a congregate living environment ie… Senior Housing. Client requests less than two hours of service NOTE: In extenuating circumstances, PSS and PSSX may be provided on the same day, but at different time intervals. **Follow-up with the client to assure:** PSA arrives timely and stays for the allotted time Follow-up and schedule a case conference as needed regarding missed visits and other problems. Clients needing both PSS and PSSX must receive these services from the same provider.

IF	THEN
Out-Of-Home Respite Care Services	Respite Care workers provide only **non- skilled** tasks and services that are normally provided by the client's caregiver. Respite Care is provided in a Division approved out- of-home respite care setting such as ALS, ADH or Nursing Facility. **NOTE:** PSS and Out-Of-Home Respite Care Services may be provided on the same day, if necessary. Services are ordered hourly or for a 12 -hour period. The need for care giver relief must be sufficient to warrant at least three hours of RC service per visit. For hourly Respite Care there is an eight hour maximum limit. Out-of-Home Respite service units may be taken in sequence in order to allow the caregiver several consecutive days of relief. Reimbursement rates differ for hourly and 12 hour visits. Refer to Policies and Procedures for Traditional/ Enhanced EDWP General Manual, Appendix S for reimbursement rates.

IF	THEN
Skilled Nursing Services (SNS) by Private Home Care Providers	Become familiar with Policies and Procedures for Skilled Nursing (SNS) by Private Home Care Providers (Traditional/ EDWP). During the time period that SNS is provided, discuss the availability of informal support resources with client/caregiver at each care plan review and reassessment. Determine if there is a relative or friend willing to learn and assume responsibility for the task(s) which meet the chronic needs of the client. Document client/caregiver responses in the care plan review assessment section **NOTE:** Proxy caregiver requests must have Skilled Nursing Services approved by the Physician on the Level of Care page or the change of service letter as well as the service order. The frequency must note one visit per day training maximum with up to 5 total training visits depending on the case complexity of tasks for aide training. SNS must remain on the care plan at a frequency of at least every 2 weeks for aide/proxy supervision. Ongoing frequency can be more often if the case is more complex and warrants additional visits. **NOTE:** Case Management is responsible for obtaining LOC SNS approval/orders. Providers are responsible for obtaining the Physician treatment orders for proxy specifics training and orders for RN skilled services. **NOTE:** SNS Traditional/ Enhanced EDWP (COS 590) and Home Health (COS 200 CNA, therapy or nursing) cannot occur on the same day and both receive payment.

	NOTE: An RN supervisory visit alone is not reimbursable by Medicaid under Traditional/ Enhanced EDWP. The RN's nursing visit must include the skilled nursing service ordered by the physician and the supervisory visit of skilled nursing A Licensed Practical Nurse (LPN) cannot complete the initial evaluation visit, develop or initiate the plan of care, or reevaluate a member enrolled in a waiver program. To support reimbursement for these requirements, Traditional/ Enhanced EDWP agencies should authorize at least one RN visit every other month on the SAF. **Example**- LPN weekly for medication compliance can have one RN visit monthly on the SAF. **NOTE:** Monthly SNS is added to the PA for ECM monitoring and Provider RN consult for enhanced nursing supervision. (PSS/PSSX) See also- Part II Chapt 1900 Traditional/ EDWP Skilled Nursing Services by Private Homecare Providers.

1845 – COST SHARE (CLIENT LIABILITY)

POLICY STATEMENT

Traditional/Enhanced EDWP Medicaid clients may be required to pay a share of the cost of their services.

POLICY BASICS

DFCS determines Traditional/ Enhanced EDWP Medicaid eligibility and the exact cost share amount that a client pays toward the cost of Traditional/ Enhanced EDWP service(s). SSI Medicaid clients are not required to pay a cost share.

Case Management discusses cost share estimates with PMAO/MAO clients during telephone screening, initial assessments, admissions, and other situations as applicable. Case Management provides clients with cost share brochures.

Case Management discusses cost share payments with clients during care reviews.

Clients and providers should be aware of the following information regarding cost share:

- After giving a 30-day notice, providers may discharge clients who fail to pay cost share.
- Providers should bill clients monthly for the cost share. Providers may avoid problems if they make efforts to collect the cost share monthly.
- Providers may collect the entire cost of services from a PMAO client or they may collect an estimated cost share. Providers make adjustments in the amount collected after DFCS approves the Medicaid and determines the exact cost share amount.

NOTE: If DFCS determines that an applicant is not eligible for Medicaid, the client is responsible for the entire cost of services delivered.

Traditional/ Enhanced EDWP Medicaid eligibility is not contingent on a client paying the cost share but on the receipt of a Medicaid waivered service. If a client's family member, neighbor or service organization chooses to pay the cost share, they should pay it directly to the provider. The amount paid by a third party to the provider for client cost share is not considered income to a client for Traditional/ Enhanced EDWP Medicaid eligibility

PROCEDURES

The DFCS Medicaid caseworker returns the CCC or a computer-generated notice to notify the Case Management of the exact cost share. The CCC also contains the following:

- Whether the client application for Medicaid was approved or denied
- Effective date of the approval/denial
- Client's Medicaid number.

NOTE: Review the CCC or notice carefully to determine if DFCS approved Medicaid for every month that the client has received Traditional/ Enhanced EDWP service(s).

After receiving the information from the DFCS Medicaid caseworker, follow these procedures:

1. Enter client Medicaid Recipient number in the electronic data system.
2. On the service order, assign client cost share collection to the provider(s) rendering the service with the greatest total monthly cost. Continue to assign cost share until there is no provider left to assign any collection responsibility.
3. When the actual cost share assigned by DFCS is less than the estimate by the RN/LPN, credit the client on future SAFs in the electronic data system. Do not have providers

void claims for previous months of care.

NOTE: The cost share assigned by DFCS should only be reconciled in the client's favor back to the month the assigned provider(s) began collecting the estimated cost share, which should begin with the month services begin after they meet LOC and all parties sign the Level of Care and Placement Instrument.

NOTE: If the actual cost share amount is determined $0 by DFCS, request the provider to void the previous claims and rebill with the corrected SAF that has the new cost share on Gammis from the electronic data system.

4. When the actual cost share assigned by DFCS is greater than the estimate by the RN/LPN, adjust the next month's SAF after rollover and change to the corrected cost share ongoing. Do not have providers void claims for previous months of care.

5. You may choose to create SAFs and 'pend' and not send to Gammis until the final approval from DFCS with the determined amount.

6. No cost share assignment is to be applied to a PA in the first month of Medicaid approval by DFCS.

EXAMPLE: Client cost share is $400. Provider A delivers $300 in services, provider B delivers $150, and provider C delivers $27.

First, assign $300 of the cost share/collection to provider A, $100 of cost share collection to provider B, and zero to provider C. Provider A collects $300 and provider B collects $100 from the client, but provider C does not collect any cost share.

7. Advise client of the amount of monthly cost share (client liability) and which provider to pay.

NOTE: Case Management alone is considered a waivered service. Client choice of limited care (Case Management alone) is allowed if chosen by client, while in Medicaid pending status.

NOTE: The client pays the entire cost share or the actual costs of services, whichever is less.

8. Send SAFs to providers to notify them of client's Medicaid number, cost share, and provider(s) assigned to collect the cost share.

9. If a provider discharges a client who fails to pay the required cost share and another provider agrees to serve the client, arrange for the other provider to render services.

NOTE: When rebrokering services, Case Management or CM support staff, inform subsequent providers if the client failed to pay the required cost share to the previous providers.

10. If no other provider agrees to deliver the service that was discontinued, but the client receives another service, send a Form 5382 to advise client of the reduction in service. Assign provider responsibility for cost share collection.
11. If the client no longer receives a service, use a Form 5382 to send a termination notice to the client. Use the CCC to notify DFCS that the client no longer receives a waivered service.

1846 – Traditional/ Enhanced CASE MANAGEMENT SUPERVISION

SUMMARY STATEMENTS

DCH will monitor case management agencies to assure the performance of local supervision in accordance with established rules, regulations, policies and procedures.

BASIC CONSIDERATIONS

Each case management agency is required to provide monthly quality assurance and chart monitoring as routine supervision activities. At minimum, supervisory reviews must include a review of the monthly case record activities completed by each Case Management. Case Management activities include but are not limited to the following:

> MDS assessments, care plan review assessments, monthly contact assessments, complaint logs, incidents, case conferences and other applicable assessments in the electronic data system.

A review of additional tabs in the electronic data system should also include reviews of work performed in the Service Order, Notes and SAF tabs.

A combination of internal quality assurance templates that track paper file documents and the use of HAR reports run monthly are recommended for thorough quality oversight.

PROCEDURES

Step 1 Generate, in the case management software program, client activity reports for the preceding calendar month

Step 2 Identify and review client records, by assigned Case Management, to ensure that each Case Management is represented in the monthly monitoring activity

Step 3 Generate monitoring reports in case management software to trend results and identify the need for remediation interventions

When completing case record reviews, auditors will give special attention to the following documentation:

- Completed Level of Care and Placement Instrument and LOC crosswalk

- Comprehensive care plan, especially triggers, client assessment protocols, interventions and triage level

- Minimum Data Set-Home Care (MDS-HC) documentation which supports LOC eligibility and scoring between the Level of Care and Placement Instrument and the nursing assessment

- Case notes and follow-up activities-include use of the Referral and Support screen in the electronic data system
- Completed Comprehensive Care Plans

NOTE: It is the responsibility of the local Case Management agency to generate the Case Management monitoring reports monthly.

In addition to the required monthly chart record reviews, CM agencies will conduct a monthly review of the agency case terminations and Level of Care eligibility for each assessment and reassessment.

NOTE: Discharges to nursing home will be monitored to determine if appropriate follow up and interventions (increased services) were offered to maintain the client in the community.

Traditional/ Enhanced EDWP Case Management must perform:

- Regularly scheduled supervisory conferences to discuss performances and annual performance appraisal

- Regular scheduled training sessions

- Case conferences

- Standards of Promptness and waiver performance measures

1847 – Traditional/ Enhanced CASE MANAGEMENT MONITORING

SUMMARY STATEMENT

The Department of Community Health and Case Management agencies monitor Traditional/ Enhanced EDWP program activities according to the terms of the 1915c Home and Community Based Waiver and all applicable DCH policies and procedures.

BASIC CONSIDERATIONS

The following activities require monitoring:

- Compliance with Traditional/ Enhanced EDWP regulations, policies and procedures
- Programmatic and financial reports
- Case file organization
- Case notes documentation
- Complaint logs
- Incidents
- Standards of Promptness
- Follow-up
- Supervision
- HAR reporting

PROCEDURES

The Department of Community Health will perform program integrity monitoring of each local Case Management agency. The compliance site visit or electronic monitoring involves completion of a monitoring tool that surveys the provider agency's compliance with Traditional/ Enhanced EDWP program policy, supervision of the member and adherence to the member's care plan. Results of these visits can identify deficiencies that require corrective action from the agency provider. This monitoring will be conducted by the Traditional/ Enhanced EDWP Section within DCH.

NOTE: Keeping paper copies or PDF copies of assessments, notes, medications and other applicable member signed documents in a retired system/cloud for historical/audit purposes for Medicaid record retention is recommended- Part I Policies and Procedures for Medicaid/Peach Care For Kids 106R.

1848 – REASSESSMENTS

SUMMARY STATEMENT

All Traditional/ Enhanced EDWP clients are reassessed at least annually.

BASIC CONSIDERATIONS

Reassessment serves the following purposes:

- re-determines a client's level of care (LOC) certification
- re-determines ECM or TCM level eligibility using the Nursing Supervisory Visit form/Appendix DD (for applicable services) *for ECM* and the *Defining ECM form.*
- affirms each client's continued eligibility appropriateness, and need for

- evaluates client progress toward achieving Comprehensive Care Plan (CCP)
- allows for adjustment of the CCP which serves as the client's medical plan of treatment for all providers except Home Delivered Services (HDS)
- permits the Case Management to continue authorizing needed services

Reassessments are conducted annually and the level of care is to be sent to Alliant Health Solutions (AHS) for validation purposes.

NOTE: Reassessment requests by Alliant Health Solutions (AHS) may occur more often than annually regarding provisional certifications that are less than 365 days to support a new Level of Care.

NOTE: The LPN may conduct the client visit and complete the care plan but only the RN may determine client LOC certification.

The intermediate LOC for nursing home placement is determined at every reassessment by the RN Case Management or the LPN Case Management under the RN's supervision.

Begin reassessment as early as 3 months but no less than 2 months prior to the expiration of the LOC

Use the following procedures to prepare for and conduct reassessment activities:

PROCEDURES (PRIOR TO REASSESSMENT)

STEP 1	Use the computerized "Case Management Tickler Report for Reassessments" from the electronic data system to track annual reassessments
STEP 2	Call and schedule a visit at a convenient time for the client/caregiver to reassess service needs
STEP 3	Request additional medical record information from physician or the agency's Medical Director or provider(s), using the EDWP Physicians Evaluation form

NOTE:
While medical record submission is not required for all level of care reviews, any reviews that fall in the following categories may be supported by medical records:

- Assessments that reflect functional impairment not clearly associated with a medical diagnosis
- Assessments that reflect one or more behavioral health diagnoses with functional impairment not clearly associated with a medical diagnosis

- Assessments that reflect diagnoses not typically expected to result in long term functional impairment such as hip fracture or knee replacement

Alliant Health Solutions and/or DCH staff may request and/or retrieve medical records to support any level of care determination. The request is for the purpose of determining eligibility. Information may include hospitalization information, medical equipment needs, previous treatment, and medical history.

STEP 4 Review client information prior to the home visit to conduct the face to face interview

The following assessment forms are used to complete the annual assessment:

- Traditional/ Enhanced EDWP Level of Care and Placement Instrument
- Minimum Data Set – Home Care (MDS-HC v9)
- Comprehensive Care Plan (CCP) including Risk/Goals, Service Order and Task List and Evaluations
- Medication/ Diagnosis updates
- Informed Consent (signature page) and Authorization for Release of Information (Form 5459), if needed
- Nutrition Screening Initiative (NSI), Checklist and Client Referral Form - Home Delivered Meals, if applicable
- Client Detail

PROCEDURES (DURING THE ANNUAL ASSESSMENT HOME VISIT)

Determine if Traditional/ Enhanced EDWP services are still appropriate using the

STEP 1 MDS-HC to assess changes in the following areas:

- medical condition
- functional status
- cognitive ability
- environmental safety
- caregiver support/burden

STEP 2 Conduct the reassessment

NOTE: Any applicant or member of the E&D Waiver Program for whom English is not the applicant's/member's primary language must be provided interpreting services in their native language for all initial assessment for program admission, annual reassessment, or any time when a change in condition will require a new evaluation of need. The interpreting services must be provided by an independent, conflict free agency, organization or contractor with no organizational affiliation to the case management or service provider agency **or relationship to the applicant/member**. A documented record of the interpreter or interpretation agency, including all contact information (i.e. complete name, address, phone number and email), must be maintained by the agency or service provider agency that secured the interpretation service and will be made available to DCH upon its request as part of the applicant's/member's file. If the applicant's or waiver member's care is managed by a legal guardian, the interpretation requirements outlined hereinabove will also apply to the legal guardian.

The use of Medical Interpreters is necessary to ensure members are ESL (English as Second Language) are understood in their native language and conflict free case management standards are maintained.

STEP 3 Complete a new CCP based on the client's current situation

NOTE: If the client receives ADH or ALS, at minimum, review the following in the clinical record:

- progress notes
- RN supervisory notes
- documentation of any additional services rendered
- current medication list and Medication Administration Record (MAR)
- physician orders
- hospital admission notes, if applicable
- provider care plan
- incident reports

STEP 4 Check, with the client's permission, the refrigerator/freezer for those clients receiving HDM, to monitor meal consumption and to assure that proper food temperature can be maintained

NOTE: If the client appears to be accumulating meals, discuss the situation with the client. Determine the appropriate intervention depending on client's reason for not eating the meals.

STEP 5 Complete and obtain client/client representative's signature on the Informed Consent (signature page) and the Authorization for Release of Information (5459), if needed

STEP 6 Update the discharge plan and emergency disaster plan in consultation with the client/family, the client's physician or the agency's Medical Director and

other involved service agencies and other available local resources

STEP 7 Complete Advanced Assessments when indicated

STEP 8 Complete other activities specific to the client's situation

PROCEDURES (AFTER THE REASSESSMENT HOME VISIT)

STEP 1 Document reassessment activities in client record, requesting necessary medical information from the physician or provider(s), if needed for MDS completion and eligibility determination.

STEP 2 Review entire assessment along with any additional medical record information provided by the physician, (EDWP Physician Evaluation Medical Form), to determine eligibility for Alliant Health Solutions (AHS) validation process.

STEP 3 Upload the following documents to Alliant Health Solutions (AHS) via the MMIS for validation of the LOC:

- Level of Care and Placement Instrument (current and prior year)
- Alliant Health Solutions (AHS) Assessment Reports in PDF
  - including MDS (which includes the ILOC Crosswalk), case notes, medications and diagnosis
- applicable advanced assessments
- physician medical record documentation and/or the EDWP Physician Evaluation Medical Form
- client detail report
- Previous year's approved Level of Care Placement Instrument that confirms dementia diagnosis (if applicable)

NOTE: Alliant Health Solutions (AHS) will start the new prior authorization PA on the day following the expiration date on the current Level of Care and Placement Instrument

NOTE: When Alliant Health Solutions (AHS) issues a second LOC approval that extends a previous short term loc (6 mos) you can attach the contact us documentation to a EDWP Notification Form for each provider for them to keep a hard copy for their files. Submitting a second LOC to the MD is an option, dating the new LOC upon the termination of the previous short term loc. Client would need to re-sign with a new date and the new LOC extension can be listed at the bottom of the Level of Care and Placement Instrument. Submit all completed copies to each provider.

STEP 4 Send the validated Level of Care and Placement Instrument (noting Alliant Health Solutions (AHS) date span approval), Service Order and LOC page to client's physician or the agency's Medical Director.. The physician or the agency's Medical Director/nurse practitioner completes, signs, and returns the

documents to the Case Management.

NOTE: Submit the *ECM DM Physician letter* initially and annually (for TCM/Traditional Case Management) to the primary care physician if the Level of Care and Placement Instrument is signed by the agency's Medical Director. Submit the *ECM DM Physician letter* initially and every 6 months for ECM/Enhanced Case Management.

STEP 5 RN certifies the LOC – Length of Stay will not exceed 365 days beyond the LOC validation date

STEP 6 Broker changes in current service or new service, if necessary

NOTE: If ordering a therapeutic meal, it must be indicated on the LOC

page.

STEP 7 Provide needed follow-up and document all related activities

STEP 8 Send via confidential facsimile, a copy of the following documents to providers:

- copy of LOC page
- copy of signed Authorization for Release of Information and Informed Consent (signature page)
- other relevant information such as psychological and psychiatric evaluations or any information relative to the client service needs which will be beneficial to the to the provider prior to his/her completion of an evaluation/assessment

STEP 9 Send the following electronic documents via secure electronic mail:

MDS-HC and CCP generated from the electronic data system which includes the following:

- Client Detail
- DON-R (derived)
- Client Assessment Protocols (CAPS), Risk/Goals
- Service Order
- Medication/Diagnosis tabs
- Task List/Evaluations

NOTE: When completing a CCP review and reassessment at the same time, be mindful of the expiration date of the CCP and provide the reassessment care plan to the provider agency within the standard of promptness. Send the CCP packet via secure electronic mail as an

attachment.

STEP 10 Send the NSI and Client Referral Form-Home Delivered Meals and Appendix C HDM policy manual form to the Traditional/ Enhanced EDWP HDM provider when brokering this service; update reassessment date in the electronic data system and create SAFs when the provider sends the EDWP Notification Form indicating the date that new/revised services were delivered

NOTE: If the nurse determines the need for a new service requiring a physician's or the agency's Medical Director order when conducting an annual assessment for a new length of stay, the nurse must request the physician's order using the change of service letter to cover the remaining days of the current length of stay, with the understanding that the physician's signature for approval of services on the new Level of Care and Placement Instrument will apply to the new length of stay.

Example: Current LOC from Alliant Health Solutions (AHS) is 10/5/14-10/4/15 and annual reassessment visit is conducted on 8/2/15 with the need for addition of ADH. RN/LPN will complete the annual reassessment adding existing and new care to line 23 of the Level of Care and Placement Instrument while also completing the change of service letter for the physician or the agency's Medical Director which will cover the immediate addition of the ADH, upon physician or the agency's Medical Director approval, as Alliant Health Solutions (AHS) certification of the new LOC will begin 10/5/15, upon expiration of the old LOC.

NOTE: Change in service letter should be sent upon completion of visit if the RN/LPN determines the service addition/change is needed immediately, prior to the Alliant Health Solutions (AHS) validation for the new length of stay.

NOTE: Once the physician or the agency's Medical Director./nurse practitioner/physician assistant signs the LOC page, the Case Management does not change the services listed on the Level of Care and Placement Instrument.

CHART 1848.1 ACTIVITIES WHEN CLIENT NO LONGER MEETS LOC AFTER REASSESSMENT

IF	THEN
Client no longer meets LOC criteria.	Upload appropriate work for Alliant Health Solutions (AHS) level review/validation of LOC.
Client no longer eligible for any reason other than LOC.	Send Notice of Denial, Termination or Reduction in Service, Form 5382, to client stating reason for ineligibility.

Client termination from Traditional/ Enhanced EDWP	Schedule meeting with client/representative for review, planning and execution of current discharge planning checklist.
Client wants to appeal adverse action.	Follow appeal procedures.

1849 – ONGOING ACTIVITIES

POLICY STATEMENT

Activities required by the Traditional/ Enhanced EDWP are coordinated among the AAA, Case Management, and service providers.

POLICY BASICS

Activities discussed in this section are conducted regularly when working with Traditional/ Enhanced EDWP clients. It is helpful to understand which activities are dealt with at the local level and those which require assistance from the Department of Community Health or Division of Medical Assistance (DMA).

Activities include:

- Address changes - inside PSA and transfers
- Case Management conferences
- Interruptions in service
- Medicare home health and Traditional/ Enhanced EDWP
- Provider requests for changes in services
- SAF changes including:
  - Billing edits
  - Overrides
  - Prior approvals
  - Third party reimbursements.
- Terminations.

1850 – ADDRESS CHANGES

POLICY STATEMENT

Case Management, providers, and DFCS inform each other immediately when a client's address changes.

POLICY BASIC

- The Case Management updates client address changes in the electronic data system and communicates the new address information via the appropriate electronic communication form (EDWP Notification Form or CCC)

- Case Management is responsible for Case Management activities for all Traditional/ Enhanced EDWP clients who live within their assigned areas.

NOTE: When a client moves to a new PSA, a reassessment may be necessary if the transferred Alliant Health Solutions (AHS) PA will expire in the next 90 days.

PROCEDURES

Use procedures in Chart 1850.1 when processing address changes for active Traditional/ Enhanced EDWP clients:

CHART 1850.1 – ADDRESS CHANGES

IF	THEN
Client plans to move or has already moved within the PSA	1. Update the electronic data system Basic Client Screen with the new address. 2. Change Case Management assignment in the electronic data system. 3. Notify provider(s) of client's new address.
SSI Medicaid client moves	In addition to the steps 1-3 above, advise client to contact SSA to update the mailing address for Medicaid card.

MAO or PMAO client moves within the same or to another PSA	In addition to the steps 1-3 above, verbally notify MAO caseworker of new address. • Within 3 business days after verbal notification, follow up with a completed CCC, Form 5590 to the county DFCS office.
Client moves to another PSA and Case Management determines that client continues to need Traditional/ Enhanced EDWP services in the new PSA	• Update the electronic data system Basic Client Screen/demographics with the new address. • Make a copy of the documents in the case record for retention by the transferring office. Forward original "hard copy" client record, by mail to the receiving PSA.

Client moves within the same PSA or out of the PSA but no longer wants services at new address	• Request letter from client or authorized representative stating that services are not wanted at the new address. • Send completed Form 5382 to advise client of the termination because of the request to voluntarily terminate services. • Terminate client from services using termination procedures. Do not continue services during the 30 day notice.
Client moves without notifying the Case Management	Attempt to locate client through the following means: • U. S. Postal Service (certified letter) • Provider(s) • DFCS • Family members or neighbors Document efforts to locate client in client's case record.
Case Management unable to locate the client	• Use Form 5382 to send a termination notice to client's last known address and proceed with termination process. • File returned mail in client's case record with envelope intact to verify attempt to deliver termination notice.

1851 – TRANSFERS

SUMMARY STATEMENT

Traditional/ Enhanced EDWP clients may transfer to another PSA or transfer from SOURCE to Traditional/ Enhanced EDWP / or from Traditional/ Enhanced EDWP to SOURCE and remain eligible for The Elderly and Disabled Waiver.

BASIC CONSIDERATIONS

Case Management and providers work together to assure that Waiver clients successfully transfer from one PSA or agency to another without experiencing unnecessary interruptions in services.

PROCEDURES

Responsibilities of transferring Case Management Traditional/ Enhanced EDWP to Traditional/ Enhanced EDWP:

STEP 1 Obtain the new address and name of the county where the client is moving or has moved.

STEP 2 The Lead at the Case Management agency or the Lead Programmatic staff member will notify the case management agency in the receiving area regarding the following:

- proposed date transfer will occur
- reason for transfer
- client's service needs
- other pertinent information

NOTE: Initial clients no longer require service begin in the area in which they were assessed in order to transfer to the receiving area, regardless of DON-R score at initial assessment.

STEP 3 Complete the following activities to update the case management system with the following client information:

- update the client demographics with the new address information
- add the end date for the current Case Management with the reason code for the transfer and select the PSA to which the client is transferring
- if transfer is to a SOURCE agency, proceed with termination from Traditional/ Enhanced EDWP
- Complete the transfer form and upload to Alliant, notifying Alliant Health Solutions (AHS) via "contact us" of the need for the PA transfer. Upload the completed form as well as the current/signed/approved LOC page in formal notes in the electronic data system.

If a client moves to a PSA not served by current provider, transfer copies of provider clinical records or case summaries to the receiving Case Management.

STEP 4 Copy all documents in the original case record to create a duplicate case to retain, indicating date of transfer, client's new address and county of residence. File a copy of the CCC in the original and duplicate case records. For MAO and PMAO clients, send CCC, Form 5590 to DFCS

STEP 5 If file is going to another Traditional/ Enhanced EDWP site, or a case management site that is active in the electronic data system, transfer entire original record of signed documents from initial placement in the program (Release of Information, Right to Appeal, Rights and Responsibilities etc) along with all Level of Care and Placement Instruments and Informed Consents as able to the receiving Case Management by certified mail with return receipt requested. If file is going to a SOURCE site, transfer the last year of work to the SOURCE agency including the MDS, Care Plan, SAF, Formal Notes, ILOC, and Level of Care and Placement Instrument.

Responsibilities of the receiving Case Management Traditional/ Enhanced EDWP to Traditional/ Enhanced EDWP:

- review client record in the electronic data system
- update with Case Management assignment begin date
- arrange interim services, if needed
- within five business days, conduct a face-to-face visit with client to complete a CCP
- broker services with provider(s)
- ensure the update of the service order units and frequency and generate the SAF when the service begin date(s) in the new PSA is confirmed

NOTE: The receiving PSA can make adjustments to all SAFs.

- send CCC, Form 5590 to DFCS

- when received, review record to assure that all forms are in the file. Contact transferring PSA for missing documents

PROCEDURES

Traditional/ Enhanced EDWP and SOURCE transfers/admissions:

- Transferring site will submit a Waiver Transfer form to Alliant Health Solutions (AHS) via-"contact us" email informing them of the receiving agency's information. Form location at https://www.mmis.georgia.gov/portal/default.aspx. Transferring site will also complete the 'transfer supplement' and send it to DCH along with the waiver transfer form for collaborative work between the two sites involved.
- Communicate with new/receiving agency and fax/email the following documents to the

receiving agency: MDS HC 9, Level of Care and Placement Instrument, transfer form, transfer supplement, one year of case notes and current care plan/care path.

The receiving Case Management site will be assigned a new PA #. You can enter that PA number in the existing MDS in the electronic data system, applicable section, overriding the existing PA number if the member file already exists in the application. You may also prefer to create a new, shell MDS= initial, listing that new PA. If the file is CCSP to CCSP, the MDS could = recert as well when you recreate.

- When receiving a transfer from a SOURCE site, refer to Policy 1825 and screen clients at the ADRC level for immediate placement to the Case Management for admission and transfer. No waitlist is required. The AAA will utilize the submitted 'waiver transfer form' and transfer supplement that is uploaded during the referral to the AAA. The forms will assist with processing the file to the new CCSP site.
- Upon receipt of the file from the SOURCE site and referral from the ADRC, the RN/LPN will make a face-to-face visit with the 5- day SOP per policy 1836.
- A complete initial assessment is **not** required for Alliant Health Solutions (AHS) if the PA will not expire in 90 days as Alliant Health Solutions (AHS) will have moved the PA from the transferring agency to the new site. No extension of the PA will be given.
- An MDS shell does need completed for tickler and programmatic purposes, type=initial. If the transferred PA will expire within the next 90 days, a full *initial* MDS will need completed and processed to Alliant Health Solutions (AHS).
  - During the nurse face-to-face assessment, if no new MDS is needed, complete the case notes and service order, and request a physician's order using the change of service letter if applicable during the performance of the EDWP Modified Reassessment should service changes be required for the remainder of the length of stay. A Source to CCSP transfer will require a Modified assessment, change of service letter and ECM HAR or Defining ECM Conference form to continue as ECM
- The entire MDS from the SOURCE site can be entered in the electronic data system or just minimal requirements for tickler/programmatic purposes. The MDS will be coded as an initial. The MDS in the system needs to reflect the next due PA date given by Alliant Health Solutions (AHS) that will reflect the previous SOURCE PA. The MDS also needs to reflect the RN approval date for entry into EDWP - Tradition/Enhanced for programmatic purposes.
- The RN/LPN is to evaluate for service needs during this initial home visit and follow policy for brokering upon return to the office.

- The Case Management will follow with a 90- day visit, omitting the 30 day visit requirement and performing the required monthly assessments before the quarterly visit is due.

NOTE: All necessary/applicable documents listed in 1826 (#1-8) continue to be required for chart processing for the SOURCE to Traditional/ Enhanced EDWP transfers.

NOTE:

- If you already performed an initial MDS in the electronic data system, not knowing there was an existing SOURCE PA, your MDS in the system needs to reflect the next due PA date given by Alliant Health Solutions (AHS) that will reflect the previous SOURCE PA. The MDS also needs to reflect the RN approval date for entry into Traditional/ Enhanced EDWP for programmatic purposes.
- Obtain the documents from the SOURCE site or from the Alliant Health Solutions (AHS) site.
- Obtain the completed Level of Care and Placement Instrument from SOURCE
- When brokering, use the **SOURCE** MDS and Level of Care and Placement Instrument in

addition to the Traditional/ Enhanced EDWP Service Order/Care Plan from the electronic data system.

- Clearly explain to receiving providers via the EDWP Notification Form that documents received will be a combination of existing SOURCE and new Traditional/ Enhanced EDWP documents.

NOTE: Transfers from SOURCE to Traditional/ Enhanced EDWP no longer require care to begin on day one of the next month. Traditional/ Enhanced EDWP to SOURCE transfers (and vice versa) can now occur on other than the end of the month. The discharge date from one to the other due to transfer needs to be agreed upon in advance so the worker can end date the services PA before the new services PA begins and the two service PAs don't overlap. The LOC PA can be transferred between Traditional/ Enhanced EDWP and SOURCE if it's unexpired

NOTE: Transfers to ICWP are recommended on the first day of the month with communication between case managements occurring in the month prior to the transfer.

NOTE- Billing claims to Georgia Medicaid for reimbursement of case management services provided to Traditional/ Enhanced EDWP members became a part of Georgia's Elderly and Disabled Waiver with the approval of the 5-year waiver cycle that began on October 1, 2017.

Case Management agencies will bill code T2022 or T2022SE at a rate of $175.00/$192.27 monthly.

NOTE:

The area the client is leaving, the sending area, whether SOURCE, ICWP or Traditional/ Enhanced EDWP, will bill for the month the transfer occurred if performance of the assessment has taken place for that month. The receiving area will bill the next month and ongoing after the transfer took place.

NOTE: A client rebrokering a Case Management agency or relocating from an ECM/TCM Case Management site to another will have member choice of agency if moving to an area with multiple agencies. The transferring or rebrokering area will explain all Care Management options and document client choice with a signed *Member Choice Form* and begin the transfer/rebroker process noted above. The M*ember Choice Form* must be signed by the client and uploaded as an attachment to formal notes. The choice confirmation can be received via email or text message from the member and can be saved in formal notes as an attachment, The confirmation must be in writing.

*A trans in/out status is needed in the provider enrollment tab for the changes above.

A move from an ECM/TCM site to another ECM/TCM site, within the same Case Management agency, does not require a 'transfer in/out' in the provider enrollment tab. The existing Case Management agency will end one day and the new site will start the next. A home visit by the new/receiving agency is also not needed as it is the same agency, just a different office belonging to that agency. Both offices will coordinate care should new service providers need ordered and services/frequency changes need to take place. A new planned service and new PA/SAF will need to be set up for the receiving agency in the electronic data system. A transfer form will need sent to Alliant for the purpose of the LOC PA transfer.

1852 – CASE MANAGEMENTCONFERENCES POLICY STATEMENT

Case Management schedules conferences when changes in a client's situation or issues with service delivery call for special interventions. Documentation of the conference is entered in the electronic data system as an assessment and a formal note type.

POLICY BASICS

A Case Management conference is often the best approach to resolving a difficult situation. Participants assure that:

- Case Management conferences result in group acceptance of each participant's role and responsibility for following through with an intervention plan.
- Agencies respect the position from which others act.
- Mutual agreement on the expected outcome results in successful problem resolution.

PROCEDURES

A Case Management agency leads the meeting and is responsible for the following activities:

- defining the purpose and focus of the conference
- deciding whether the client or the care giver attends (Depending upon the nature of the problem, it may not be possible to involve the client in the Case Management conference)
- including all agencies and persons involved in the case
- arranging a location for the conference
- notifying participants to attend
- determining what information about the client is shared with conference participants. The Case Management shares only the information necessary to assist with the problem resolution.
- arranging for official minutes to be taken and distributed within five days of the conference
- clarifying the plans of action agreed upon during the conference
- giving everyone present a chance to be heard
- documenting Case Management conference results in the client's case record
- advising each conference participant of the outcome of the intervention.

NOTE: Case Conference assessments are performed in the electronic data system with the client/caregiver and Traditional/ Enhanced EDWP service specific agency prior to the rebrokering of a client from an agency. The conference can be telephonic. The client can choose not to participate. The conference intent is to allow all parties to communicate and resolve outstanding issues, thus, preventing billing overlap due to missed communication.

1853 – INTERRUPTIONS IN SERVICES

POLICY STATEMENT

Temporary interruptions in service do not jeopardize a client's continued eligibility for participation in the Traditional/ Enhanced EDWP. Collaborative communication between client/representative, providers and Case Management will occur to prevent unnecessary service lapse and case closure.

POLICY BASICS

The following gives examples of interruptions in service which occur most frequently:

- Temporary visits to another PSA

Clients may visit an area where his/her current providers are not enrolled to serve. Except in emergencies, prior planning and coordination with the Case Management, provider(s) and the client assures that medical needs will be met, either professionally or by an informal care giver.

- Client travel outside the state.

NOTE: Traditional/ Enhanced EDWP Medicaid eligible clients must receive a waivered service within each calendar month to maintain Medicaid eligibility but SSI Medicaid clients do not.

- Client hospitalizations

Hospitalizations do not interfere with a client's Medicaid eligibility nor is the client in danger of being terminated from the Traditional/ Enhanced EDWP even if the hospital stay is more than 60 days since no break in service occurs.

- Nursing home placement for less than thirty days

A client placed for less than 30 days in a nursing home does not lose Traditional/ Enhanced EDWP eligibility but the client will need the nurse to make a face-to-face assessment of that condition, update the case notes and service order, complete the EDWP Modified Reassessment and request a physician's order using the change of service letter to cover potential new service additions for the remainder of the length of stay. The most common reasons for temporary placements are convalescent care from a hospitalization and temporary absence or incapacity of the care giver.

NOTE: Failure of Traditional/ Enhanced EDWP clients to communicate with Case Management and providers may result in interruptions in service.

PROCEDURES

Advise clients to always report changes in their situations. Use procedures in Chart 1853.1 when clients have interruptions of service.

NOTE: Advise MAO clients to discuss their plans with DFCS so that interruptions in services do

not result in Traditional/ Enhanced EDWP Medicaid ineligibility.

CHART 1853.1 – INTERRUPTIONS IN SERVICE

IF	THEN
Client temporarily visits in another PSA AND Needs service(s) during the visit	Take the following action: • Plan in advance with the client and the caregiver. • If the current provider is approved to deliver services in the PSA where the client will visit, arrange for the provider to continue to deliver the client's services. If not, determine if the client is willing to choose another provider that delivers service in both PSAs. Explain to the client and providers that the services may resume with the current provider after the visit. OR • Transfer the case to the other PSA where services will be brokered with a provider. • Remain in close contact with the Case Management in the PSA where the client is visiting to assure that client needs are being met.
	NOTE: Use CCC, Form 5590 to notify DFCS when a MAO client does not receive a waivered service for 30 days.

Client travels outside the state	Advise client to use procedures shown on the back of the Medicaid card to obtain medical care. Communication with client/representative must occur frequently to prevent a lapse in services, avoiding 60-day service coverage loss, discharge as active status in Traditional/ Enhanced EDWP thus resulting in Traditional/ Enhanced EDWP Medicaid benefits termination recommendation for MAO clients.
Client is hospitalized	• Hospital discharge planners are responsible for knowing a client's medical and social situation and arranging services when discharged from the hospital. • Inform discharge planners that the patient is a Traditional/ Enhanced EDWP client to avoid any of the following: o discharge planner referring client to a provider other than the Traditional/ Enhanced EDWP provider currently serving client o discharge planner ordering Medicare or Medicaid home health services without the knowledge of the Traditional/ Enhanced EDWP provider or Case Management o client entering a nursing home without the knowledge of the provider or Case Management o client being discharged without Case Management determining whether the medical condition warrants a face-to-face assessment of that condition/change with needed updates of the case notes and care plan by the Traditional/ Enhanced EDWP nurse staff prior to discharge.

Client placed in a nursing home for less than 30 days	Temporary placements in nursing home facilities do not affect eligibility for Traditional/ Enhanced EDWP or Medicaid, provided the RN/LPN: • The nurse must make a face-to-face assessment of that condition, update the case notes and service order, complete the EDWP Modified Reassessment and request a physician's order using the change of service letter to cover potential new service additions for the remainder of the length of stay. Case Management assures that services are in place when the client returns home.

1854 – MEDICARE HOME HEALTH AND Traditional/ Enhanced EDWP POLICY

STATEMENT

Traditional/ Enhanced EDWP clients may receive Medicare home health services and remain eligible for Traditional/ Enhanced EDWP services.

POLICY BASICS

Medicare services include the following:

- Skilled nursing visits
- Home health aide visits
- Physical therapy
- Medical social services
- Occupational therapy
- Speech therapy

Medicare services are the same services that a client would receive from home health in Traditional/ Enhanced EDWP. Therefore, if an individual is receiving Medicare home health services at initial assessment, the client meets the Traditional/ Enhanced EDWP Medicaid requirement of waivered service receipt.

NOTE: MAO clients terminated from Traditional/ Enhanced EDWP may lose their eligibility for Medicaid. Case Management must refer MAO clients terminated from the Traditional/ Enhanced EDWP to DFCS for Medicaid eligibility determination. Clients terminated from the Traditional/ Enhanced EDWP may reapply when their situations change.

If a client receives Medicare or Medicaid home health services, they must be delivered by the same provider**.**

PROCEDURES

Medicaid home health providers:

- Use EDWP Notification Form, Form 6500 to notify Case Management whenever a client is receiving any of the above six services through Medicare.
- Indicate on EDWP Notification Form, Form 6500 the anticipated duration of the Medicare covered services.

Communicate regularly with the Medicare provider to monitor the duration of Medicare services.

Do not authorize Medicare home health services on the SAF.

When Medicare home health services replace Medicaid home health services, adjust the SAF to reflect the change. When Medicare benefits end, the Traditional/ Enhanced EDWP enrolled provider uses the EDWP Notification Form to notify the Case Management. If necessary, complete a reassessment to determine if the client will need additional services from Traditional/ Enhanced EDWP.

When a Traditional/ Enhanced EDWP client receives Medicare home health services from a provider, the Case Management:

- Contacts the Medicare provider
- Determines which Medicare services are provided
- Coordinates Traditional/ Enhanced EDWP and Medicare care plan
- Requests verbal or written notification of any Medicare increase, decrease or termination.

When a client receives Medicare services, follow the procedures in Chart 1854.1:

CHART 1854.1 – MEDICARE STATUS CHANGES

IF	THEN
Client receives only Medicare services for more than 60 days and provider expects Medicare services to continue indefinitely	Determine whether client needs additional Traditional/ Enhanced EDWP services. OR If Medicare home health services alone meet the client's needs
Medicare home health services alone will meet the client's medical needs indefinitely **NOTE**: Do not keep this type of client in the Traditional/ Enhanced EDWP to continue Medicaid eligibility.	Use Form 5382 to advise client of termination from the Traditional/ Enhanced EDWP.

1855 – PROVIDER REQUESTS CHANGE IN SERVICE UNITS SUMMARY

STATEMENT

Traditional/ Enhanced EDWP providers and/or family members may request from the Case Management, an increase or decrease in the client's units of service.

BASIC CONSIDERATION

The Case Management, who is responsible for managing client care, approves or disapproves all increases or decreases in a client's authorized units of service.

PROCEDURES

Use the following procedures (Chart 1855.1) when a change in services is requested:

CHART 1855.1 – PROVIDER REQUESTS FOR CHANGE IN SERVICE UNITS

IF	THEN
Provider notifies Case Management (via EDWP Notification Form) of change in client's condition and requests an increase or a decrease in the number of authorized service units **NOTE:** A Provider may not automatically make a change in service without prior approval from the Case Management.	Case Management completes the following activities: 1. Contacts the Provider to determine the reason for the request 2. Discusses the change with client or care giver 3. Approves or disapproves the provider's request and documents in the case record the discussion with provider and reason for decision 4. Within three business days after receipt, signs dates and returns the EDWP Notification Form to the provider 5. Determines whether client needs a reassessment
Case Management agrees with Provider that client's situation has changed but the circumstances do not require a reassessment	1. Using the electronic data system, the CM creates a new service order record which reflects changes in service units. 2. Generate the SAF for affected month ("historical" if current month and "new" if future month) with the number of service units and forward a copy of the new SAF to the Provider by fax or secure electronic mail

IF	THEN
Case Management agrees with Provider AND Client's situation has changed significantly; therefore, a reassessment is required **NOTE:** Determine if situation requires an RN or LPN to complete the reassessment.	Case Management: 1. Discuss client's condition with Provider and client's Physician or the agency's Medical Director. 2. Complete steps 1-3 above 3. Conducts reassessment **NOTE:** If Case Management's recommendation and the Physician's care plan conflict, consult with the client's Physician or the agency's Medical Director. to resolve the situation.
Provider increases service units delivered without first obtaining Case Management prior approval AND No reassessment is required EXAMPLE: Providers increasing services without talking to Case Management for approval and then sending EDWP Notification Form request after services are delivered.	If increase in service units is justified, Case Management: 1. Completes steps 1-3 above If increase in service units is unjustified, Case Management: 1. Sends EDWP Notification Form back to the Provider advising that increase was not approved 2. Does not generate historical or new service order or create SAFs 3. Provider(s) cannot bill for the unauthorized services rendered **NOTE:** Report to the DCH any Provider who repeatedly disregards this requirement.

1856 – SAF CHANGES

POLICY STATEMENT

Service Authorization Forms (SAF) are initiated only by Case Management to authorize services.

POLICY BASICS

Case Management uses the SAF to authorize reimbursements for services rendered.

The Case Management agency generates and maintains SAF data. However, unique situations occur that require the assistance of DCH and/or DMA.

The most common situations which require Division assistance with the SAF are:

- Overrides:

  The local level can update a SAF up to six months after service delivery. For adjustments of more than six months, an override is necessary from the Department of Community Health.

- Billing edits:

  The electronic data system and the Division of Medical Assistance's Medicaid Management Information System (MMIS) use billing edits to block payment to claims. Both computer systems use automated processing and auditing. Billing edits in MMIS block payment of claims that have data inconsistent with the information in the electronic data system.

- Third party reimbursement:

  Some Traditional/ Enhanced EDWP clients have Medicare or private insurance coverage. The provider is responsible for billing for third party reimbursement first and then billing the balance to Medicaid.

PROCEDURES

When a provider requests an adjusted SAF because it reflects less units than actually provided, determine if an override is justified.

Use the procedures in Chart 1856.1 to adjust an SAF when an override is justified:

CHART 1856.1 – OVERRIDE PROCEDURES

IF	THEN
Override needed because service delivery date more than six months ago	The Provider: • Sends Case Management EDWP Notification Form requesting the increase in units on the SAF. The Case Management: • If the increase is justified, requests override from the Department of Community Health.

IF	THEN
Case Management approves override request	• Care Coordination changes the SAF. AND • Case Management generates the SAF, forwards a copy to provider with EDWP Notification Form, and files original in client file. • Provider bills DMA for services.
The Case Management denies override request	• Case Management uses EDWP Notification Form to notify provider of decision.

NOTE:
Refer to Chapter 1000 and 1009 of the PART II – Chapters 600 to 1000 POLICIES and PROCEDURES For ELDERLY AND DISABLED WAIVER PROGRAM (EDWP)-(CCSP and SOURCE) GENERAL SERVICES MANUAL regarding the basis of reimbursement and Appendix S for rates and procedure codes.

1857 – BILLING EDITS

POLICY STATEMENT

DMA's fiscal agent processes Medicaid claims only if they are timely and correct. Billing edits are employed to block payment of claims that are inconsistent with the Medicaid Management Information System (MMIS).

POLICY BASICS

GAINWELL TECHNOLOGIES Technology is under contract with DMA to reimburse Medicaid provider(s) and operate the Provider Enrollment Unit. GHP distributes information about enrollment, trains Medicaid providers in the billing process, and reimburses them for authorized services. GHP also operates the Billing Inquiry Unit to assist Medicaid providers with questions related to billing.

DMA's fiscal agent, GAINWELL TECHNOLOGIES, uses the MMIS which processes and audits provider claims using a prior authorization electronic format. The Medicaid billing form captures the necessary data for the MMIS.

DMA's fiscal agent pays claims only if they are received by the end of the sixth month following the month services are rendered. Claims over six months old and claims adjustments require special handling to pay a provider.

PROCEDURES

Upon receipt of EDWP Notification Form from provider documenting that services have begun: the following activities occur:

1. Case Management authorize services for clients on the Service Authorization Form (SAF) in the electronic data system**.**

2. After the SAF information is entered into the electronic data system, SAF data is available to the Information and Technology (IT) Section of DCH Office of Technology and Support.

3. From IT, SAF information is transferred to DMA's MMIS.

    - DMA's MMIS contains client eligibility information that matches with Social Security Administration and DFCS client eligibility information.

    - If SAF information does not match DMA's MMIS files, system audits and edits stop the SAF transfer to DMA's MMIS.

4. After delivering services, providers use the SAF received from the Case Management to prepare their claims and submit them to GAINWELL TECHNOLOGIES either electronically or by mail. The claim information submitted by the provider must also match the MMIS/DMA system for payment to be made.

Apply the deadlines in Chart 1857.1 regarding Traditional/ Enhanced EDWP provider payments submitted to GAINWELL TECHNOLOGIES:

CHART 1857.1 BILLING DEADLINES

BILLING SITUATION	TIMELINESS
Claim submitted for services rendered AND Client is Medicaid eligible	DMA allows 6 months from the end of service month to submit initial claim.
Claim submitted for client determined retroactively eligible for Medicaid	6 months from month in which eligibility was determined.
Claim submitted with third party payers	12 months following month of service.
Claim denied for Medicare, resubmitted for Medicaid	3 months following date Medicare claim was denied.
Denied claim resubmitted	6 months following month of service or by end of 3rd month following denial.
Claim submitted for adjustment	3 months from month of payment, accompanied by adjustment request form and Remittance Advice.

If unable to resolve the provider's billing problem, ask the provider to use the following procedures:

- Attach the Remittance Advice
- Attach copy of the SAF
- Mail all of the above to DMA, P.O. Box 38426, Atlanta, GA 30334.

1858 – THIRD PARTY REIMBURSEMENTS

POLICY STATEMENT

If a Traditional/ Enhanced EDWP client's Traditional/ Enhanced EDWP services are covered by any other third- party insurance, the Traditional/ Enhanced EDWP provider must first bill the third party insurance carrier before billing Medicaid.

POLICY BASICS

Some Traditional/ Enhanced EDWP clients have health insurance policies which pay toward the cost of skilled health services provided by the Traditional/ Enhanced EDWP.

PROCEDURES

For clients with third party insurance, the Case Management lists on the Service Authorization Form (SAF) all services and units of service ordered on the initial plan of care.

The provider submits an invoice to DMA for reimbursement of the balance of the cost of services not covered by the Traditional/ Enhanced EDWP client's third- party insurance.

It is not necessary for the provider to send a EDWP Notification Form to the Case Management to deauthorize third party units that were reimbursed. DMA coordinates third party insurance payments for Medicaid clients.

1859 – TERMINATIONS

POLICY STATEMENT

Traditional/ Enhanced EDWP clients who no longer meet the eligibility requirements, move out of state, or no longer wish to participate in the Traditional/ Enhanced EDWP are discharged from the Traditional/ Enhanced EDWP program.

POLICY BASICS

The RN/ Case Management terminates clients from the Traditional/ Enhanced EDWP. DMA's Utilization Review Team (UR) and providers may discharge a client's service. Clients may appeal RN/ Case Management and UR adverse action decisions.

RN Case Management may use the following termination reasons when terminating clients from the Traditional/ Enhanced EDWP by documenting client program status in the electronic data system. This list is not exhaustive, if Case Management believes that there is a reason for termination that is not included on this list as provided for guidance, please contact your Case Management Specialist for further assistance.

1. Client no longer meets level of care criteria: After assessment, RN Case Management determines that the client no longer meets the

LOC. Example:

a. Your physical limitations do not meet the required level of care to be eligible for the Traditional/ Enhanced EDWP. Based on your physical condition, you are able to meet your basic care needs with minimal difficulty.

NOTE: An RN level of care denial at the local level will have the documentation submitted to Alliant Health Solutions (AHS) for a second level validation. The RN will choose "not recommended" on the MDS in the electronic data system.

NOTE: Termination reason #1 requires specific examples and detailed information noted on the termination letter for clarity and hearing purposes.

2. Client no longer meets level of impairment criteria: After assessment, RN Case Management determines that the client no longer meets the level of impairment.

(Required description of specific abilities and factors that led to determination).

NOTE: Termination reason #2 requires specific examples and detailed information noted on the termination letter for clarity and hearing purposes.

3. UR recommends discharge/termination: UR recommends the client discharge from service and this recommendation is upheld in the UR appeal process. Follow Department of Community Health (DCH) appeal guidelines and collaborate with client/representative regarding appeal procedures received.

NOTE: Termination reason #3 requires specific examples and detailed information noted on the termination letter for clarity and hearing purposes.

4. No services provided for 60 consecutive days: The enrolled client has not received a waivered service for 60 consecutive days, (exception: When the client is hospitalized) (Case Management notes last day services were rendered)

a. Medicare/Medicaid Home Health/Hospice Care is meeting your needs at this time.

NOTE: Termination reason #4 requires specific examples and detailed information noted on the termination letter for clarity and hearing purposes.

5. Death of client: The client dies. (Case Management notes date of death verifying with caregiver/provider and other involved sources)

NOTE: Termination reason #5 requires specific examples and detailed information noted on the termination letter for clarity and hearing purposes.

6. Client refused service/requested termination: The client refuses service and/or requests termination from the Traditional/ Enhanced EDWP.

7. Moved out of state: The client moves out of state.

8. Client entered nursing home/facility: The client enters a long-term care facility on a permanent basis.

NOTE: If a client enters a nursing facility for a temporary stay, the Case Management does not send a termination notice until notified the placement is permanent.

NOTE: #6-8, Case Management notes the specifics of the termination answering who, what, where, when, how and why.

9. Other: Use this code for terminations that do not fit the other reasons.

Examples:

a. Your services exceed the average annual cost of Medicaid reimbursed care provided in a nursing facility. Provide brief description of specifics

b. You exhibited and/or allowed illegal behavior in the home; or you or others living in the home have inflicted or threatened bodily harm to another person within the past 30 calendar days. Provide brief description of specific

c. You chose a Non CT/MFP facility for relocation from your nursing home setting and this makes your placement in the Traditional/ Enhanced EDWP waiver as a traditional client void and subject to return to the waitlist

d. You have exhausted the available list of providers in your area to service you for your choice of specific service(s)

e. You do not have physician approval for a care plan.

f. You are not Medicaid or potentially Traditional/ Enhanced EDWP Medicaid eligible because…….

i. Your $ XXXX.00 monthly income exceeds the $ XXXX.00 (2015) Traditional/ Enhanced EDWP Medicaid income limit. If you wish to establish a Qualifying Income Trust to be income eligible for Traditional/ Enhanced EDWP Medicaid, please contact

your county DFCS office at_____.

ii. Your $XXXX in resources exceeds the $2000 Traditional/ Enhanced EDWP Medicaid resource limit for a single person. (add here the spousal resource limit too?)

iii. You failed to complete the application process at the local DFCS office

g. Your health and safety needs cannot be met by the Traditional/ Enhanced EDWP. Provide brief description of specifics

h. You may receive services from only one waiver program at a time. You are currently receiving services from the (ICWP/SOURCE/NOW/COMP or other) waiver and you indicated you choose to remain in_____.

NOTE: In the event where a case is being transferred from one waiver to another (Traditional/ Enhanced EDWP vs ICWP/Source/NOW COMP) the RN Case Management must verify with the other waiver regarding begin and end dates for the current and new service. Communication between the waivers must be documented in formal case notes verifying the transition process including name and contact information for each waiver. Service transitioning can occur during the month and no longer is needed to take place on day one of the next month.

i. Home Delivered Meals is the only service you need. To be eligible for Traditional/ Enhanced EDWP, you must need another service in addition to Home Delivered Meals.

j. We have been unable to contact you or you failed to provide the necessary information needed to determine your continued eligibility for Traditional/ Enhanced EDWP.

NOTE: In cases of termination other than death, the Case Management notifies the primary care physician or the agency's Medical Director that his/her patient has been discharged from the Traditional/ Enhanced EDWP.

NOTE: Termination reasons above #1-9 require specific examples and detailed information noted on the termination letter for clarity and hearing purposes. Add policy citations to the termination letter for clarity and specify service end dates versus waiver program termination dates on the termination letters.

PROCEDURES

Use the procedures in Chart 1859.1 when discharging clients from the Traditional/ Enhanced EDWP:

CHART 1859.1 TERMINATION PROCEDURES

IF	THEN
Provider sends 30 day discharge notice advising client of the reason and effective date of discharge AND Sends Case Management a EDWP Notification Form advising of client's proposed discharge. Provider attaches a copy of the discharge notice sent to client and a copy of the final summary report. **NOTE:** If a provider discharges a client who exhibits and/or allows illegal behavior in the home or client or others living in the home have inflicted or threatened bodily harm to another person within the past 30 calendar days, the provider does not have to provide services through the effective date of discharge notice.	If Case Management determines client continues to need the service, Case Management uses client choice to broker the service with another provider. If no provider is willing to accept the client and the client is no longer receiving a service, Case Management sends a completed Form 5382 advising client of termination from Traditional/ Enhanced EDWP. Case Management follows Section 1841 and 1861regarding discharge planning and appeal rights for client/representative.
Provider discharges client who fails to pay cost share	Case Management attempts to re-broker services with another provider. BUT No provider is willing to accept the client and the client is no longer receiving a service. Case Management sends a completed Form 5382 to the client. Case Management follows Section 1841 and 1861regarding discharge planning and appeal rights for client/representative.
Provider sends 30 day discharge notice advising client of reason and effective date of discharge AND Case Management determines client is no longer eligible for service(s)	Case Management sends a completed Form 5382, stating the reason for termination in service AND Provides Case Management services until the termination date. Case Management follows Section 1841 and 1861 regarding discharge planning and appeal rights for client/representative.

Client is in an acute care hospital more than 60 days	If client plans to return to Traditional/ Enhanced EDWP, Case Management does not send adverse action notice BUT The nurse completes a home visit when the client is discharged from the hospital with change of service letter + performance of the EDWP Modified Reassessment if applicable.
Client is discharged from the hospital AND No longer receives services from providers participating in Traditional/ Enhanced EDWP **NOTE:** Give client the option of choosing a Traditional/ Enhanced EDWP provider.	Case Management sends adverse action notice, Form 5382, advising client of termination from the Traditional/ Enhanced EDWP. Case Management follows Section 1841 and 1861 regarding discharge planning and appeal rights for client/representative. **NOTE:** A non-approved provider cannot request reimbursement from Traditional/ Enhanced EDWP. To ensure coordination of appropriate service delivery, notify hospital discharge planners when a Traditional/ Enhanced EDWP client enters the hospital.
A MAO or PMAO client is terminated from the Traditional/ Enhanced EDWP	Case Management sends CCC, Form 5590, to DFCS on the same day that the Form 5382 is mailed to client. **NOTE:** If client entered a nursing home, include the name of the facility on the CCC. Case Management follows Section 1841 and 1861 regarding discharge planning and appeal rights for client/representative.

MAO or PMAO client requests a fair hearing	Case Management and DFCS coordinate the hearing request with DCH Legal Services. AND Case Management notifies provider(s) of the client's appeal.

Member remains in the nursing home for 100 days (unless the discharge plan is a return to the community) Documentation will be in place with frequent follow-up to the client regarding the needed decision to remain or return to a community setting.	The Case Management agency will need to finalize the termination process in the electronic data system and end the ***service*** PA on Gammis by setting SAFs to the appropriate units. If the person applies for Traditional/ Enhanced EDWP after they have been discharged, it will be considered an initial assessment/reinstatement if applicable. The previous LOC PA at Alliant Health Solutions (AHS) can be left to expire. No termination of the LOC PA is needed.
RN or Alliant Health Solutions (AHS) determines that the client no longer meets Level of Care Criteria and client requests a hearing RN or Alliant Health Solutions (AHS) determines that client no longer meets Level of Care Criteria and client does not request a hearing	Follow procedures in 1860-1863 + 1869 AND Case Management notifies provider(s) of the client's appeal. Provide Traditional/ Enhanced EDWP services to the client until the end of the expiration of the previously approved PA. Discharge notification letters are located at https://www.mmis.georgia.gov/portal/PubAccess.Provider%20Information/Provider%20Manuals/tabId/54/Default.aspx "EDWP Case Management Documents". Allow the LOC PA to expire at Alliant Health Solutions (AHS).

To close a case record, complete the following activities:

In the electronic data system - Update the following:

- Complete case closure in the Divisions, Programs and Provider Enrollments tabs.
- Send copies of revised SAFs to provider(s).

EXCEPTION: If client appeals the adverse action, the case remains active during the hearing process.

NOTE: Case Management follows Section 1841 and 1861 regarding discharge planning and appeal rights for client/representative.

1860 – Traditional/ Enhanced EDWP APPEALS POLICY STATEMENT

Applicants and clients have the right to appeal decisions adversely affecting their participation in Traditional/ Enhanced EDWP.

The full appeal process includes the steps:

1. Initial hearing - a hearing conducted by an Administrative Law Judge (ALJ) from the Office of State Administrative Hearings (OSAH) on an adverse action decision made by the Case Management, DFCS, or utilization review (UR).

2. Final review- an administrative review that a client may request if the ALJ upholds the adverse action. If OSAH's decision appears to be a misapplication of Traditional/ Enhanced EDWP policy that will have an impact on other cases, the Department of Community Health may request a final review. The Department may not appeal disagreements on questions of fact or other matters having no impact beyond the specific case involved. To compete the final review, the DCH Commissioner's review appeals reviewer reviews the entire initial hearing record and any additional documentary evidence submitted with the request for review.

3. Judicial review - a court action to review adverse decisions on final appeals. The judicial review is conducted by a superior court in accordance with O.C.G.A, 50-13- 19 (Georgia Administrative Procedure Act).

State agency appeal hearings are open to the public (subject to provisions of confidentiality of information). Hearings must meet the due process standards set forth in the United States Supreme Court decision Goldberg v. Kelly, 397 US 254 (1970) and comply with the Standards set forth in the Georgia Administrative Procedures Act (O.C.G.A) 50-13-1., et.seq.

POLICY BASICS

The Department of Community Health, DCH, establishes Traditional Enhanced / EDWP appeal procedures. The following persons have appeal rights:

- Individuals certified or seeking certification for nursing facility care, where payment would be through the Georgia Medical Assistance Act of 1977

- Individuals subject to an adverse action (as defined herein) with regard to the EDWP Services Program.

References: Public Law 97-35, Section 2176, 42 C.F.R.
Section 431.200, et.seq., O.C.G.A. Section 49-6-60, et.seq.

An applicant/client may request a hearing to appeal any adverse action with regard to participation in the program. Adverse actions occur during one of the following activities:

- Denial at telephone screening assessment

- Removing an applicant's name from the waiting list

  EXCEPTION: Removing a name due to death of applicant.

- Denial of participant's request for increased services

- Termination of an active case.

Reasons for denying or terminating an applicant/client's eligibility for Traditional/ Enhanced EDWP include but are not limited to the following:

- Reduction or termination of service

- Denial or termination in level of care (LOC) certification from Alliant Health Solutions (AHS)

- DFCS denial or termination of Medicaid benefits

- Denial/termination based on client's request

- Level of impairment or unmet need criteria not met

- Participating in another waiver

- Unable to contact to obtain information needed to determine eligibility.

- No longer receiving a waivered service

- Entering a nursing home

- Moving out of state.

NOTE: Utilization Review analysts send adverse action notices addressing their terminations and reduction in service(s).

The information presented during the hearing is normally limited to reasons related to the adverse action(s) being appealed.

PROCEDURES

Screening specialists and Case Management use the following procedures for adverse actions:

1. Use Form 5382, Notice of Denial, Termination, or Reduction in Service, to provide client notice of adverse action other than LOC denial/termination.

2. For LOC denial/termination, submission to Alliant Health Solutions (AHS) for

validation is required. The RN will choose "not recommended" on the MDS in the electronic data system.

NOTE: At initial face-to-face assessment, use Form 5381, Notice of Right to Appeal Decisions Regarding Traditional/ Enhanced EDWP to provide appeal information to applicants/clients.

TIME FRAME: If client requests, either orally or in writing, appeal of decision within 10 days of the date of the notice of adverse decision by the case management agency, and requests that services continue while hearing is pending, services will continue until there is an administrative decision. Client must request an appeal within 30 days of the date of the notice of adverse action.

An appeal request due to a level of care denial from Alliant Health Solutions must be made within 30 days of the date of the letter from Alliant.

Follow procedures listed below for appeals:

1. Call client to determine if s/he has questions concerning the adverse action notice.

2. Assist client with hearing request as appropriate.

3. Provide telephone number for Elderly Legal Assistance Program (ELAP) or other legal assistance program.

4. Obtain written authorization from the client before disclosing contents of client case record to a third party.

5. Allow the client to examine his/her case record.

6. Review the discharge plan with the member/representative as well as provide contact information to the Area Aging on Aging for the county of residence for available resources.

NOTE: If the client has a legal guardian or lawyer, communicate with the client only through the legal representative.

Coordinate appeal information that affects service with providers. If a client appeals a case management reduction/denial within 10 days, services may continue as usual until a decision is made on the appeal.

When processing an initial hearing request, whether verbal or in writing, submit the following documents or copies to DCH General Counsel within three days of receipt of the hearing request:

1. Completed and signed Request for Hearing, Form 5383 or member's written statement with member signature.

2. Notice to client of action(s) being appealed, Alliant Health Solutions (AHS) denial letter, Case Management 5382 or denial/termination Level of Care letters.

3. Any documents, medical records, and other materials upon which the agency relied for the adverse action if denial at the Case Management level.

4. Excerpts from regulations supporting the adverse action if denial at the Case Management level.

5. Most recent LOC page, MDS-HC, and CCP, if denial at the Case Management level.

Send appeal requests to the following address:

Department of Community Health
2 MLK Jr. Drive SE
Twin Towers East
General Counsel
18th Floor, Atlanta, GA
30304

NOTE: Send a copy of the appeal packet to DCH CM Specialist. A client may submit his/her appeal request directly to Case Management. Case Management will submit the appeal to DCH Legal Services.

Before the hearing occurs, communicate with DCH legal and the member for possible telephone or case conference to review the adverse action and the individual's circumstances to determine if an adjustment should be made. Under no circumstances should any effort be made to discourage the client from pursuing the appeal.

Use procedures in the following Chart 1860.1 for PMAO/MAO clients requesting appeals:

CHART 1860.1 – PMAO/MAO CLIENT'S APPEAL REQUEST

IF	THEN
Client files an initial hearing request from a case management reduction/denial within 10 days but does not wish to continue receiving service OR Client files an initial hearing request after 10 days	Send a Communicator advising DFCS caseworker that the client is no longer in service AND Coordinate the hearing process with DFCS to collaborate and update DFCS regarding Traditional/ Enhanced EDWP MAO cases
Client remains in service but the ALJ's initial hearing decision upholds the adverse action. AND Client does not want to file a final review request	Send a Communicator advising DFCS caseworker that the client is no longer in service.

Client remains in service but the final review decision upholds the adverse action. **NOTE:** Service stops immediately unless client obtains a court order to continue service.	Call the client to discuss the outcome of the final appeal. Send a Communicator advising DFCS caseworker that the client is no longer in service. **NOTE:** Implement the final decision but do not send a new adverse action notice to client.
Client wishes to appeal adverse action terminating his/her Medicaid eligibility	Client contacts DFCS caseworker to file an appeal.

Use procedures in the following Chart 1860.2 to handle changes that occur during the hearing process:

CHART 1860.2 – CHANGES WHILE HEARING IS PENDING

IF	THEN
Client appeals an adverse action, either by the local RN or by Alliant Health Solutions (AHS), continues to receive service, and the LOC will expire before the hearing decision or final review becomes final	RN does NOT complete a LOC redetermination. **NOTE:** Providers may continue to deliver services. Legal will communicate with Alliant Health Solutions (AHS) for a PA extension or Case Management can request via 'contact us' re a 4 month PA extension for the appeal process.
Client needs an increase in service because of a change in his/her condition or situation	Case Management follows procedures for increasing service and notifies the ALJ or Appeals Reviewer.
Client needs a decrease in service because of a change in his/her condition or situation	Case Management follows procedures for decreasing service, sends another adverse action notice to client, and follows appeal procedures.
DMA, DFCS, AAA, or Case Management reverses or amends adverse action decision	Responsible agency contacts the OSAH or DCH Legal Services immediately to provide the new information.

NOTE: Alliant Health Solutions (AHS) will extend expired LOCs by a length of time necessary to complete the appeal process, usually 4 months. Review the "contact us" communication on their website. Submit that communication along with a EDWP Notification Form to each provider to cover the existing expired LOC. Refer them to General Services Manual 605.1H as needed.

1861 – LEGAL ASSISTANCE

POLICY STATEMENT

A Traditional/ Enhanced EDWP client has the right to represent him/herself or have an attorney, paralegal, or any other person represent him/her.

POLICY BASICS

Legal Assistance services are available at no cost to Traditional/ Enhanced EDWP clients who are 60 years old or older through:

- Title III/Older Americans Act (OAA) funded programs
- Georgia Legal Services (GLSP)
- Atlanta Legal Aid Society (ALAS).

Clients may also choose independent legal counsel.

PROCEDURES

Case Management follows these procedures for client legal services:

1. Become acquainted with the legal service providers in their areas.

2. Notify individuals of the availability of these services.

3. Assist applicants/clients in accessing legal assistance services when desired.

1862 – INITIAL ASSESSMENT APPEAL

POLICY STATEMENT

An applicant has the right to appeal a denial at initial assessment. Level of care eligibility determination by the local RN will be processed to Alliant Health Solutions (AHS) for further validation. The RN will choose "not recommend" on the MDS in the electronic data system.

POLICY BASICS

The RN Case Management processes fair hearing requests on denials at initial assessments.

PROCEDURES

Use the following procedures for appeals of denial at assessment:

1. Send Forms 5382 and 5383 to advise applicant that s/he is not appropriate for Traditional/ Enhanced EDWP at initial assessment for reasons other than level of care denial.

NOTE: Do not use Form 5382 for LOC denial/termination. Level of Care ineligibility

determination by the RN proceeds to Alliant Health Solutions (AHS) for validation determination.

2. Use the following Chart 1862.1for procedures when an applicant files an appeal of a denial at initial assessment:

CHART 1862.1 – APPEALING AN INITIAL ASSESSMENT

IF	THEN
Applicant wants to appeal	Applicant/authorized representative files verbal or written request for an initial hearing with the Case Management within 30 calendar days from the date on Form 5382/LOC denial letter(s).
Applicant verbally requests a hearing	Even though not filed on Form 5383, the applicant must request the appeal within 30 calendar days from the notice of adverse action. Within three days, the Case Management sends the request to DCH Legal Services and asks the client to submit a written request.

1863 – LEVEL OF CARE APPEAL PROCEDURES

POLICY STATEMENT

An applicant has the right to appeal a denial of the LOC certification. An active Traditional/ Enhanced EDWP client has the right to appeal termination of the LOC certification.

POLICY BASICS

A LOC certification denial or termination may occur during initial assessment or during reassessment. These denials are done only by Alliant Health Solutions (AHS), not the local level RN. See Chapter 1869 for LOC denial procedures by Alliant Health Solutions (AHS).

1864 – OUTCOME OF INITIAL HEARING

POLICY STATEMENT

The OSAH decides the outcomes of applicants/clients' initial appeal hearings.

POLICY BASICS

The OSAH notifies the client of the outcome of the initial hearing.

The ALJ's initial decision becomes final when either of the following situations occur:

- If the decision is favorable to the client
- If decision is unfavorable, 30 days after the decision unless the client requests a final review.

PROCEDURES

If the ALJ rules in favor of the client, the AAA or Case Management agency reverses the adverse action immediately.

If the ALJ upholds the adverse action taken by the AAA or agency, the OSAH sends a notice

of the decision to the client. When an adverse action decision is upheld, Case Management follows procedures shown below in Chart 1864.1:

CHART 1864.1 – ADVERSE ACTION UPHELD ON INITIAL APPEAL

AGENCY	ACTION TO TAKE
OSAH	Send client initial decision with explanation of final review procedures AND Send copies of decision to parties listed on the Hearing Summary Form.
AAA or Case Management	Call individual to determine if s/he has questions concerning the ALJ's decision AND Assist individual in filing final review, if requested, AND Provide information requested by the DHS appeals reviewer.

1865 – FINAL APPEALS

POLICY STATEMENT

Applicants/clients have the right to request final review of initial ALJ decisions.

POLICY BASICS

The Office of State Administrative Hearings notifies the applicant/client of the outcome of the final review.

The appeals reviewer at The Office of State Administrative Hearings conducts the final review. The appeals reviewer may provide for the taking of additional testimony, argument or evidence by the parties or representatives. In addition, the appeals reviewer may request a response from the agency responsible for initiating the adverse action.

The usual 90 day standard of promptness is waived for rendering the final decision. The final decision and notice includes findings of fact and conclusions of law, separately stated, and the effective date of the decision.

PROCEDURES

The responsible agency uses procedures in the following Chart 1865.1 to process requests for final reviews:

CHART 1865.1 – FINAL APPEAL PROCEDURES

IF	THEN
Client files a final review request	Applicant/client files a letter with the Case Management AAA, or the DCH Legal Services Office within 30 days from date on initial decision requesting a final review. AND Clients receiving services may continue their services until the appeals reviewer makes a final decision. **NOTE:** Applicants filing appeals on denials at initial assessments do not receive any services.
AAA or Case Management wishes to file a final review request	Within 10 days of the decision, the AAA or Case Management sends the request to the Department of Community Health for a review of the ALJ's decision.
	The Department of Community Health forwards the request to The Office of State Administrative Hearings or returns it to the Case Management.
Appeals reviewer rules in favor of the applicant/client at final review	Case Management (RN) reverses the adverse action immediately. **NOTE:** The above applies provided client physician or the agency's Medical Director.certifies that the client may receive services at home without danger to him/herself or others.

Appeals reviewer does not rule in favor of the applicant/client at final review	The Office of State Administrative Hearings notifies applicant/client in writing of the decision of the appeals reviewer and of right to a judicial review. Case Management files a copy of the decision in the applicant/client's file. Case Management completes the following activities for clients receiving services: 1. Terminates Traditional/ Enhanced EDWP services immediately, based on the termination notice sent to client which prompted the initial appeal, unless modified by the final decision. 2. Advises the provider that the adverse action decision was upheld in final decision. 3. Coordinates client's discharge planning with the provider(s), client and family. 4. Refers client to other resources, if appropriate. **NOTE:** Do not send a new adverse action notice to the applicant/client.

1866 – UTILIZATION REVIEW

POLICY STATEMENT

A client may appeal adverse action decisions made by Utilization Review (UR), DMA.

POLICY BASICS

UR conducts reviews of Traditional/ Enhanced EDWP providers for the following reasons:

- To assure medical necessity of continued care
- To determine effectiveness of care being rendered
- To assure compliance with DMA policies and procedures.

To appeal UR adverse action decisions, clients may file appeals through Case Management or DFCS. Clients may file appeals directly to DCH Legal Services. Clients have the same appeal rights for UR adverse actions as they do for AAA and Case Management adverse actions.

PROCEDURES

UR reviews provider client records and conducts in-home or on- site audits to interview clients. UR conducts visits annually to every Traditional/ Enhanced EDWP provider, and more frequently, if necessary. The following are procedures for UR:

- DMA sends the provider a copy of the UR review report. If UR recommends reduction or termination of service, the UR analyst notifies the Traditional/ Enhanced EDWP provider five calendar days before sending the notice to the client.

- DMA notifies the Traditional/ Enhanced EDWP client in writing of reduction or termination of services. DMA also sends a copy of the client notification letter to DCH Legal Services.

- The UR analyst forwards a copy of the provider notification which lists clients affected by adverse actions to the AAA and to the DCH.

Case Management:

- Contact the client to determine if s/he has questions concerning the UR adverse action notice.
- Assist the client with the appeals process, but the request for the initial hearing must come from the client or an authorized representative.
- If the client files a hearing request within 10 days of the date of the UR notice and wants to continue to receive service, advise the provider to continue services during the hearing process.

NOTE: Providers continue to receive Medicaid reimbursements during the appeal process.

- If the client files a request, follow the appeal procedures.

- If UR terminates the only service that a client receives, and client does not request an appeal, send Form 5382 to advise the client of the termination of Case Management.

1867 – WITHDRAWAL OF HEARING REQUEST BY CLIENT

POLICY STATEMENT

An applicant/client or authorized representative may at any time withdraw a request for an initial hearing or final review.

POLICY BASICS

If the parties involved in the hearing request reach a mutually satisfactory decision prior to the hearing, an applicant/client may choose to withdraw the request.

NOTE: Under no circumstances may a Case Management attempt to convince or coerce the applicant/client to withdraw the request.

DMA, county DFCS staff, or Case Management may amend or reverse adverse actions at any time prior to a decision regardless of the client's decision to withdraw the request.

PROCEDURES

Use the procedures in the Chart 1867.1 below for withdrawing a fair hearing request:

CHART 1867.1 – WITHDRAWAL OF HEARING REQUEST

IF	THEN
Client or authorized representative verbally withdraws the initial hearing or review request	AAA or Case Management calls the DCH Legal Services or Office of State Administrative Hearings (OSAH) immediately. DCH Legal Services or OSAH sends a letter to the client confirming the withdrawal and canceling of the hearing. AND Sends copies of the letter to the responsible agency and other agencies involved in the appeal.

Client or authorized representative requests in writing withdrawal of initial hearing or review request	AAA or Case Management calls the DCH Legal Services or OSAH immediately. AND Copies letter for client file and forwards original to DCH Legal Services or OSAH. DCH Legal Services or OSAH sends a letter to the client confirming the withdrawal and canceling of the hearing. AND Sends copies of the letter to the responsible agency and other agencies involved with the appeal.

Client withdraws the hearing request before it is forwarded to the DCH Legal Services.	AAA or Case Management forwards to the DCH Legal Services the request for a fair hearing and the request to withdraw it. The DCH Legal Services sends a letter to the client confirming the withdrawal of the request for a fair hearing.

1868 – TIME LIMITS

POLICY STATEMENT

All requests for an appeal, unrelated to LOC denials/terminations, will be processed within established standards.

POLICY BASICS

The Case Management, DFCS, and the OSAH assure a client the opportunity for a fair hearing.

PROCEDURES

Use the information in the following standard of promptness Chart 1868.1 to determine the time limits for hearing activities:

CHART 1868.1 – STANDARD OF PROMPTNESS FOR HEARING

ACTIVITY	STANDARD OF PROMPTNESS FOR REQUEST
Client files an initial hearing request	30 calendar days from the date on the notice of adverse action.
Client files an initial hearing request to continue current services	10 calendar days from the date on the notice of adverse action. **NOTE:** Case Management advises provider to continue current services. Medicaid will reimburse for Traditional/ Enhanced EDWP services during the fair hearing process.

Client files an oral request for an initial hearing at the local agency	Written request must follow within 15 calendar days after the oral request is filed.
Responsible agency (AAA or DFCS) forwards client request to the DCH Legal Services Office for review	Within 3 working days of receipt of hearing request.
OSAH's Administrative Law Judge (ALJ) conducts hearing and issues initial decision	OSAH has 90 calendar days from date request is filed to render a decision on an initial hearing request. OSAH may waive the time limit for good cause. **NOTE:** Standard of promptness for rendering a decision may be waived on a final review.
ALJ decides in favor of client	Adverse action is reversed immediately.
ALJ's decision appears to be a misapplication of Traditional/ Enhanced EDWP policy	Within 30 days of the initial decision, the Case Management or the Department of Community Health may request a final review.
AAA or Case Management agency request a final review	The AAA and Case Management file their final appeal requests with the Department within 10 days of the initial hearing decision.
ALJ's decision is <u>not</u> in favor of client	Decision final if client does not request a final review within 30 days.
Client files a final review request	Must be requested within 30 calendar days from the date of the initial hearing decision.
Appeals reviewer rules in favor of client	Adverse action is reversed immediately.

Appeals reviewer decision is not in favor of client	Decision is final immediately. Services stop immediately unless the client obtains a court order to continue service. **NOTE:** The Department of Community Health does not have the right to appeal a final review decision.
Client files a judicial review with court system	Must be requested within 30 calendar days from the date of the decision of the DCH appeals reviewer. **NOTE:** DCH Legal Services Office must be notified within 7 calendar days of the filing.
Client withdraws request for an initial hearing or final appeal	Adverse action is effective immediately.
Case Management reverses adverse action decision	May be done at any time prior to a hearing decision. DCH Legal Services and OSAH must be notified within 2 days.
OSAH renders a decision without knowledge that the Case Management reversed the adverse action decision	Immediately review the OSAH decision to determine if it is applicable.

1869 – Alliant Health Solutions (AHS) **LEVEL OF CARE APPEAL PROCEDURES**

POLICY STATEMENT

An applicant has the right to appeal a denial of the Level of Care (LOC) validation from Alliant Health Solutions (AHS). An active Traditional/ Enhanced EDWP client has the right to appeal termination of the LOC validation from Alliant Health Solutions (AHS).

POLICY BASICS

A LOC validation denial or termination may occur during initial assessment or during reassessment.

PROCEDURES

When Alliant Health Solutions (AHS) denies or terminates a LOC validation, Case Management uses the following procedures listed in Chart 1869.1:

CHART 1869.1 – Alliant Health Solutions (AHS) LOC VALIDATION DENIAL AND TERMINATIONS

IF	THEN
Traditional/ Enhanced EDWP RN determines client meets LOC approval	Traditional/ Enhanced EDWP RN uploads documents to the Provider Workspace page
Receipt of Initial Technical Denial from Alliant Health Solutions (AHS)	CM reviews "no reply" email and determine what documents are missing and return to Alliant Health Solutions (AHS) within 5 calendar days Standard of Promptness (SOP) from Level of Care (LOC) request date. Attach missing documents to the denial Prior Authorization (PA); do not submit a new PA. Go to "contact us", enter PA number in the text of the email and state that you added the documents.
Receipt of Final Technical Denial	If CM does not follow steps from the initial technical denial above, (due to no document attachments to the LOC) within 30 days from the LOC request date or when required documentation is incomplete within 30 calendar days from LOC request date. The notice will be sent to the member for annual reassessments, not for initial assessments. There are no appeal rights for initial assessments as no services are in place. There are no reconsiderations for initial technical denials.
Initial Decision/Approved	CM reviews as case rendered approved when the LOC is complete and meets LOC criteria upon initial RN LOC review.

Initial Decision/Nurse Denial and receipt of email notification with message identifier beginning with "C", retrieve the denial letter in the messages on the Provider Workspace page.	CM reviews as case rendered when the LOC is complete, but does not meet LOC/policy guidelines upon initial RN LOC review. Member/Provider may request a reconsideration of this decision by sending additional medical information to Alliant Health Solutions (AHS) within thirty (30) calendar days of the date of the notice of denial/termination of LOC. Letter will be attached to web portal. If Traditional/ Enhanced EDWP does not obtain additional medical information or request a hearing within thirty (30) days, this decision will become final. Member has thirty (30) days from the date of this letter to request a hearing. If hearing is a verbal request, the member must submit a written request within fifteen (15) days from the date of the verbal request. Clients must send their hearing request to the Traditional/ Enhanced EDWP Case Management, and the Case Management will send the request to DCH Legal Services within the thirty (30) day deadline for submission. The DCH Legal Office has been designated as the lead attorney for Traditional/ Enhanced EDWP /DCH hearings. Contact information is Brittany Horton bhorton@dch.ga.gov . *Any changes in client condition should be communicated to DCH Legal for possible reassessment/re-evaluation.
Second Level Nurse Review/Approved	CM reviews as case rendered when a reconsideration of the initial nurse denial has occurred and based on the documentation submitted, the LOC now meets LOC/policy guidelines.
Second Level Nurse Review/Denied	CM reviews as case rendered when reconsideration of the initial nurse denial has occurred, but the LOC still does not meet the LOC/policy guidelines.
Initial Decision/Withdrawn	CM reviews as case could be duplicate requests. If SOURCE or Traditional/ Enhanced EDWP both submit same client, first one received by Alliant Health Solutions (AHS) will serve the client. Alliant Health Solutions (AHS) will use SS# to track duplicates.

Decision notification	CM reviews as Alliant Health Solutions (AHS) decisions will be posted on the web portal the day the decision is made. CM office will receive a "no reply" email notifying them of decision. Also, decisions information will display on the "provider workspace." All denial letters will be housed in the "provider workspace" and will be sent certified mail to the member along with hearing rights.

NOTE: When Alliant Health Solutions (AHS) issues a LOC extension of 4 months for purposes of LOC approval during times of appeal requests, submit the "contact us" printout, along with a EDWP Notification Form to each provider explaining the need for documentation in the file to cover the existing expired LOC.

1870 – Electronic Data System

POLICY STATEMENT

Traditional/ Enhanced EDWP uses a computerized management information system to manage program data.

POLICY BASICS

The electronic data system:

Manages all information and referral, case management function and service authorization information for all Aging services clients including Traditional/ Enhanced EDWP clients.

Generates reports on all Case Management activities. A complete list of the names and functions of reports generated by the system is located at the portal for that electronic system.

Matches statewide service authorization information to DMA payment information to ensure proper reimbursement to providers.

The Department of Community Health and Information Technology unit provides training for data entry staff, Case Management and other Traditional/ Enhanced EDWP staff on this system.

The AAA and Case Management agency enters and maintains data on the system for all Traditional/ Enhanced EDWP clients. Program data collected in the system is available to

the Department of Community Health, the AAA and Case Management Agencies. Specific user log in and access rights are defined by the user's security and job function.

NOTE: Keeping paper copies or PDF copies of assessments, notes, medications and other applicable member signed documents in a retired system/cloud for historical/audit purposes for Medicaid record retention is recommended- Part I Policies and Procedures for Medicaid/Peach Care For Kids 106R.

1871 – SERVICE AUTHORIZATION

POLICY STATEMENT

Service authorization for Traditional/ Enhanced EDWP services is accomplished through an electronically generated Service Authorization Form (SAF) in the electronic data system.

POLICY BASICS

The SAF for a specific month may be revised as often as necessary. The computer assigns a version number to the SAF each time service authorization data is entered or changed for a specific month.

SAF data is entered at the PSA level. DCH uses the information to authorize the payments DMA makes to Traditional/Enhanced EDWP providers. The Division provides this authorization data to DMA on a weekly basis (on Thursdays) to ensure that DMA payments to Traditional/ Enhanced EDWP providers are within authorized amounts.

PROCEDURES

To authorize services for a SSI Medicaid client, send the initial SAF within three business days of receipt of the initial EDWP Notification Form from the provider(s).

For a MAO client, generate the initial SAF within three business days after receiving the EDWP Communicator (CCC), Form 5590.

Use the following procedures to generate an initial SAF:

Complete the Service Order tab in the electronic data system noting order and begin dates. Enter all Medicaid reimbursable services authorized. The system will generate SAFs based on begin dates of services once authorizations are created by the Case Management.

Check each electronic printed SAF for accuracy.

Distribute the SAF copies as follows:

- File the original SAF in client file.

NOTE: The electronic data system prints the version of the SAF requested by the Case Management.

- Forward a copy of the SAF to each Provider listed on the SAF regardless of whether the provider has units.

Use the following procedures to generate changes to SAFs:

Revise the existing SAF or, if needed, change the Service Order and provider name(s) and service frequency to update services authorized for a client. Changes which require a new SAF include the following:

- Adjustments in monthly units of service
- Increases or decreases in client cost share
- Re-assignment of client cost share
- Deletion or addition of a service.

Check the revised electronic SAF for accuracy.

Distribute copies.

1872 – CONSUMER DIRECTION

SUMMARY STATEMENT

The Department of Community Health, Home and Community Based Services Medicaid Waiver, Traditional/ Enhanced Waiver Program offers a Consumer-Directed Services option for Personal Support Services (CD-PSS). CD-PSS supports client choice and independence and promotes increased client participation in care planning and budgeting, service delivery, and the freedom to hire, supervise and train his/her PSS care giver. Other Traditional/ Enhanced EDWP Waiver services, identified on the Comprehensive Care Plan (CCP) are provided by enrolled provider agencies.

Information about the Traditional/ Enhanced EDWP and CD-PSS is available through local Area Agencies on Aging, ADRC Services, and Traditional/ Enhanced EDWP Case Management agencies. Written information is available in the Traditional Enhanced / EDWP Fact Sheet Brochure. New clients and families receive information about the Consumer Direction option at Intake and Screening and again during the face to face Initial Assessment. Clients currently enrolled in the Traditional Enhanced / EDWP and

appropriate for PSS will be educated about the new option during each Comprehensive Care Plan Review.

BASIC CONSIDERATIONS

Eligible Traditional/ Enhanced EDWP clients who choose to participate in this option of service delivery will assume the role of employer of his/her direct care worker of personal support services.

Participants, whose skills are determined appropriate to self- direct, will meet specific CD eligibility criteria.

Clients may choose to return to the traditional waiver option of PSS at any time without a lapse in services.

Non-traditional service delivery (CDO) is offered to individuals, for who personal support services are included on his/her individual comprehensive plan of care.
Personal support services are appropriate for clients living in their own/others home and who have a support network comprised of family, friends, neighbors, and others who want to have active roles in supporting the client. Clients in need of PSS require assistance in performance of the Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs). In CD-PSS, the employee/worker provides assistance with feeding, personal hygiene, toileting, bathing, dressing, transfer(s), and bowel/bladder control. The worker also assists with IADL support and housekeeping activities necessary for the health and welfare of the client.

Financial Support Services is another element of Consumer Direction. Clients selecting to direct their PSS are required to choose a Medicaid approved Fiscal Intermediary (FI). The FI provides customer friendly fiscal supports which include:

- Accounting Consultation
- Employee Background Checks
- Consumer assistance with budgeting and time sheets
- Payroll and other fiscal duties

NOTE: Costs for FI services are deducted from the client PSS budget monthly.

<u>Client/Employer Responsibility</u>

Individuals opting to manage/direct the PSS services must be willing and able to meet the responsibilities of consumer direction which include acting as the employer of record and performing essential employer functions. As employer, the client must meet certain eligibility criteria and demonstrate the ability to make decisions about staff recruitment, hiring, training, supervising, and terminating staff in addition to other employer related fiscal tasks.

The client's ability to meet and maintain the roles and responsibilities of employer will

continually assessed by the Case Management (CM).

Case Management

The role of CM in the CD-PSS Option is expanded to include the role of trainer, coach and advocate. In the role of Case Management, the CM facilitates the process of assessing, care planning, arranging, and coordinating, and delivering and evaluating service delivery to all Traditional/ Enhanced EDWP participants. As the employer's mentor, the CM educates the client about the benefits and requirements of CD-PSS and assesses the client to determine his/her ability to be an employer.

If the client is determined eligible for Consumer Direction, the CM /Support Broker assists and supports the client in his/her transition to consumer directed services.

Employees in Consumer Direction

Direct care providers/personal support aides working in the Consumer Directed option are private employees of the Traditional/ Enhanced EDWP client for whom they provide care.

All employees are required to meet certain employment criteria and qualifications prior to employment in this option.

Relatives are permitted to be employed as CD-PSS caregivers.

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While personal support services are provided by the employer's individual worker(s) in Consumer Direction, the option requires that each participant/employer have a backup plan for service delivery should his/her worker fail to report to report.

Service Authorization for Medicaid Reimbursement

Case Management authorizes CD-PSS services for Medicaid Reimbursement. Personal support services are authorized by the Department of Community Health, through their fiscal intermediary. An additional service specific provider code was assigned to enable reimbursement of the monthly Fiscal Intermediary (FI) fee.

Service Authorization Forms will reflect the number of monthly units per dollar of CD- PSS and one (1) unit of service for reimbursement of service provided by the FI. Additional policies and procedures regarding client eligibility, Employer/Employee and CM /Support Broker roles, and the Fiscal Intermediary are found in this chapter.

1873 - CONSUMER DIRECTION ELIGIBLITY

SUMMARY STATEMENT

A client may be deemed appropriate and eligible for the Consumer Directed Option (CDO) if that client meets all basic eligibility requirements for the Traditional/ Enhanced EDWP and

additional requirements specific to consumer direction for Personal Support Services (CD-PSS). Clients who fail to meet the basic eligibility for the Traditional/ Enhanced EDWP will be terminated from the program. A client is deemed inappropriate for consumer direction when the client or their representatives is unable to meet the additional requirements specific to criteria for CD-PSS in this policy section.

BASIC CONSIDERATIONS

Initial appropriateness for consumer direction is determined at the request of the client and is based upon programmatic pre-requisites and client capability.

Case Management with specialized training in CDO standards and policies, will determine the appropriateness of clients requesting self- directed services based upon the process and criteria explained in this policy. If the client is found to be inappropriate, participation in the CDO is denied or terminated. He/she may continue to receive Traditional/ Enhanced EDWP service through traditional service delivery by approved personal support service provider agencies without interruption in services.

Once a request for CD-PSS has been received, Case Management will explain the program in detail to the client and any chosen representative. They will arrange for the two required trainings as noted in sections 1874 and 1875. At any time, the client can withdraw the request for CD-PSS.

If, after the two required trainings noted in section 1874 and 1875, the requested employer is determined not to present the capacity to fulfill the criteria stated in this section and 1875, the Case Management submits that denial determination for a higher level review of the case to the AAA and DCH specialist for consideration of denial of client participation in the consumer direct option.

Other employer requests will be considered. The client will be notified of the determination that he or she is approved for or deemed not appropriate for the Consumer Directed Option at the earliest available time; the client will continue receiving services in the Traditional/ Enhanced EDWP Care Plan under 'Traditional' services.

Continued eligibility for CD-PSS will be reviewed by the Case Management throughout the client's participation in this service delivery option. If, at any time, the existing employer is determined to no longer present the capacity to fulfill the criteria stated in this section and 1876, the Case Management submits that termination determination for a higher level review of the case to the AAA and DCH specialist for consideration of termination of the current employer from participation in the consumer direct option. Case Management will work with that client and employer to determine if any modifications can be made that would bring the CD-PSS back into programs compliance. If no alternate solutions can be found and upon upper level approval, Case Management terminates client participation in CDO and returns the existing client to the traditional option.

Once determined inappropriate for CDO, there is **no appeal process.** After a period of one year, the client may again request a new determination with evidence of changes in capacity or supports to be deemed appropriate for CDO.

PROCEDURES

Case Management will assess, initially and ongoing, each client who chooses to participate in CDO to determine if the individual is appropriate to direct his/her personal support services.

Clients who participate in CDO must meet the following programmatic requirements:

- Enrollment in the Traditional/ Enhanced EDWP and receiving personal support services for a period of six consecutive months or greater

NOTE: The six consecutive months includes time receiving Pss/x care if transferring from SOURCE.

- Current Waiver Medicaid eligibility
- Current physician or the agency's Medical Director approved Comprehensive Care Plan in which personal support services (PSS) or personal support services extended (PSSX) have been ordered
- Six month history of timely and total cost share payments to service provider(s), for individuals subject to cost sharing

Clients appropriate for the consumer directed option must possess the following specific qualifications:

- Ability to demonstrate control over daily schedule and decisions
- Ability and capability to direct his or her own care or designate a representative to assume responsibility for directing care
- Cognitive ability and capability to understand and perform the tasks required to employ a worker (recruitment, interviewing, hiring, scheduling, training, supervision, disciplining, and termination). See note.
- Willing to accept responsibility for cost effective use of consumer directed PSS
- Able to demonstrate the absence of problem or symptomatic behavior(s) which places the consumer or others at risk

NOTE: Individuals with cognitive impairment, dementia or communication deficits which prevent understanding and performance of these tasks are not appropriate to direct his/her own services. If a client is unable to independently direct his/her own care, the client may select a representative to act in his/her behalf. In those situations, that representative/employer must be determined to be appropriate based on the same eligibility requirements as listed for the client/employer in this policy section.

Upon notification of the Case Management, the client may withdraw from CD-PSS and select to return to Traditional/ Enhanced EDWP 'traditional' option without consequence.

In addition to failure to meet the established criteria for initial participation in Consumer Direction, clients participating in this option will be terminated from CD-PSS should any of the following circumstances occur:

- Failure to pay monthly cost share by due date
- Incidence of problem or symptomatic behavior which has placed the client or others at risk
- Failure to maintain maximum control over daily schedule and decisions for two consecutive months
- Failure to maintain cost effectiveness in use of personal support services for two consecutive months
- Failure to stay within budget for PSS for two consecutive months
- Use of the state emergency back- up plan no more than 15 days per month for two consecutive months. State Back-up services are not to be scheduled on the same days as the use of the Cd-pss aide. Collaborative communication between the Employer, Case Management and the FI will occur prior to each State back-up aide use by a traditional provider and the Employer.
- Defined and stated goals and interventions of personal support services documented in the Client Assessment Protocols (CAPS) of the Comprehensive Care Plan are unmet for two consecutive quarters.

NOTE: If use of state emergency back- up plan for two consecutive months is the result of a delay at the Division of Family and Children Services (DFCS) and not due to client error, clients may resume entry into the CD-PSS option once Medicaid eligibility is reestablished.

Removal from participation in the CDO, without programmatic ineligibility, does not constitute termination from the Traditional/ Enhanced EDWP.

Once determined inappropriate for CDO, there is **no appeal process.** After a period of one year, the client may again request a new determination with evidence of changes in capacity or supports to be deemed appropriate for CDO.

1874 – CASE MANAGEMENT ROLES AND RESPONSIBILITIES

SUMMARY STATEMENT

Case Management is essential to the success of Consumer Direction option for Personal Support Services. Case Management assess needs, develop, implement and review care plans, make appropriate community service referrals, coordinate all services, Medicaid and non- Medicaid, and monitor service delivery and client health and safety. Additionally, in CD-PSS, Case Management, trained in CD-PSS, educate, mentor, support and monitor the eligible participants choosing to direct their Personal Support Services (PSS).

BASIC CONSIDERATIONS

Case Management will receive training in CDO at the local agency level. Initially and ongoing, Case Management mentor the client/employer, foster his/her independence and success in the consumer direction option for service delivery. Case Management are not responsible for:

- Completion and processing payroll forms
- Payroll documentation and submission
- Hiring, training, disciplining or firing employees
- Performing the duties/responsibilities of the client/employer

Case Management provide advisory assistance with these activities but the Employer/Employer Representative has the responsibility for all employment issues concerning employee(s).

PROCEDURES

<u>Assess potential Employer/Employer Representative</u>

Case Management assess consumer direction eligibility for Traditional/ Enhanced EDWP participants who request enrollment in CD-PSS, using the following:

- MDS-HC 9
- St. Louis University Mental Status (SLUMS) exam and/or Mini Mental State Exam (MMSE)
- Available medical, mental health and psycho-social documentation

CM assesses the cognitive status and behavior history of the client requesting participation in CD-PSS. Additionally, the CM reviews case notes, EDWP Notification Form s and the Comprehensive Care Plan to assess, historically, the client ability and capacity to make

decisions regarding his/her care needs and services. A full review of the client's Traditional/ Enhanced EDWP chart is helpful and appropriate to determine the client's eligibility for CD-PSS.

Training Employer/Employer Representative

Clients determined eligible for Consumer Direction, will be scheduled for one-on-one training with the Case Management. Using the Consumer Directed Option Manual Policy sections and applicable forms for the Consumer, the CM will train the client on the role of employer. CM uses training guides, developed specifically for consumer directions. Mock scenarios or role play should be utilized to assist client with his/her understanding and provide a safe environment for the client to practice his/her skills. Using the Consumer Direction Skills Inventory (training check list), the CM signs off topics as the client demonstrates an understanding of the employer task. Training for employers in consumer direction requires, at a minimum, two face to face visits. Additional visits or telephone calls may be necessary for the employer to have sufficient understanding of the role and processes required for participation in CD-PSS.

Budget Development

The Case Management, with the participation of the client, develops an individualized care plan which meets the client's service needs. Based on the cost per unit for PSS/PSSX, Traditional/ Enhanced EDWP units are converted to a dollar amount to establish the monthly budget for CD-PSS.

EXAMPLE: Client receives five (5) units of PSS daily. Medicaid reimbursement under the Traditional/ Enhanced EDWP 'traditional' service delivery option is $5.61. Five units @ $5.61 = $$28.05 x 31 days =
$8869.55 (round to the nearest dollar amount). In this example, the employer has a monthly budget of $870 in CD-PSS.

Once the budget is determined, the monthly fee ($88.00) for the Fiscal Intermediary (FI) services is deducted and the remaining budget is used for care giver (employee) salary/salaries, benefits and taxes.

EXAMPLE: $870 less $88 (FI fee) = $782 for salary, benefits and taxes

In CD-PSS, the client determines the hourly rate of pay for his/her paid care giver. CM utilizes the FI Employer Packet Calculation Sheet to educate the client about this concept and provide clarification, if needed. Medicaid reimbursement for CD-PSS is $1.00 per unit (15 minute increments). The number of CD-PSS units on the SAF will be equal to the client's budget, less the FI fee.

NOTE: Maximum hourly employee rate of pay can fluctuate by FI provider based on workman's compensation premiums and changes in employment taxes. FI providers publish rates whenever changes occur and current hourly rates. Cost to employer rates

can be accessed through the individual provider websites. At maximum rate of pay, the cost to the employer CD-PSS budget cannot exceed $18.00 per hour.

Employers who choose to pay employees at a lower hourly wage may purchase more service units with their budget dollars. However, employers paying low wages may have difficulty recruiting and retaining good employees. Competitive pay rates may vary from region to region.

NOTE: In the Traditional option and in the Consumer Directed option, care plans are developed to meet the client needs at the lowest possible cost. Client costs for services in the Traditional/ Enhanced EDWP do not exceed the cost limits established by DCH.

Back-Up Plan(s)

Participation in CD-PSS requires each Client/Employer to arrange alternative workers in the event the primary worker is unavailable to provide care. Case Management assures client/employer back up plans are documented, in writing, with names and contact information for alternate workers.

As last resort, to ensure the client receives care, the client chooses a Traditional/ Enhanced EDWP enrolled PSS provider agency as the Emergency State Back Up Plan. Clients/Employers may choose the Traditional/ Enhanced EDWP provider agency which delivered his/her services in the Traditional/Enhanced EDWP 'Traditional' Option or choose from a list of Traditional/ Enhanced EDWP enrolled provider agencies in his/her county of residency, requested from the Case Management.

Responsibility for arranging services for the Emergency State Back Up plan rests with the Client/Employer.

Client/Employers determine a service fee with the provider agency not to exceed $19.20 per hour.

NOTE: Case Management is required to provide the Traditional/ Enhanced EDWP enrolled Emergency State Back Up provider agency with the current assessment packet and care plan review documents.

<u>Budget Implementation</u>

Transitioning from the traditional option of Traditional/ Enhanced EDWP to CD-PSS is permitted on the first day of the month, once all processes are completed.

Prior to implementation of the CD option, all required activities and documentation must:

- Be completed and submitted to the appropriate entities fifteen (15) days prior to the last day of the month preceding the month in which the client begins CD- PSS. Any activity or documentation pending at the close of business fifteen days before month end will delay client participation in CD-PSS
- The Fiscal Intermediary (FI) provides a monthly statement of expenditures for review by the employer and Case Management

Service Authorization

As in the traditional option for personal support services, Service Authorization Forms (SAF), generated by the Case Management reflects the units ordered on the service order monthly. Unlike Traditional/ Enhanced EDWP 'traditional' option which delivers personal support at two levels, PSS and PSSX, CD-PSS is reimbursed under one procedure code and one reimbursement rate per unit, without regard to number of hours provided per visit.

In CD-PSS, Case Management:

- Generate and mail the initial SAF to the FI by the fifteenth day of the month prior to initial participation in CD, include a copy of the current Level of Care and Placement Instrument
- The Fiscal Intermediary files Medicaid claims against employee time sheets using the employee hourly rate of pay
- Case Management does not receive the EDWP Notification Forms related to personal support services in CD-PSS

NOTE: Consumer Direction begins on the first day of the month. This option may not be authorized for a partial month.

Flexibility of service delivery and client choice is a basic tenet of CD-PSS. Such flexibility requires diligence by the Case Management to make SAF changes timely thus avoiding reimbursement errors to the FI.

NOTE: When it is necessary for an employer to use the emergency state back up plan, the provider agency will bill and receive reimbursement through the FI.

Monitoring

In CD-PSS, Case Management continue to monitor all care activities, health and welfare, support and socialization, and client satisfaction, as required in the Traditional/ Enhanced EDWP 'traditional' option where services are delivered by Traditional/ Enhanced EDWP enrolled provider agencies.

In CD-PSS, Case Management maintains monthly contacts with the client/representative to monitor client care and provide mentoring and support to the client in his/her role as employer.

Additionally, Case Management monitors the Employer's ongoing eligibility for CD-PSS during:

- Monthly contact (via telephone or home visit)
- Regularly scheduled comprehensive care plan reviews and annual assessments.

Case Management reviews and monitors employer expenditures monthly. Expenditure reports are provided each month by the FI. Budget amounts are annualized to demonstrate budgeted dollars remaining after each pay period.

This reporting/monitoring tool assists Employers in maintaining the budget and planning for any upcoming changes. Employers with late or unpaid cost share obligations are at risk for removal from CD-PSS and appear on a suspense list found on the FI web portal. The Case Management monitors expenditures and the suspense list and reviews the information with the employer.

Service Adjustments

As in traditional/ Enhanced EDWP, authorization and approval for service adjustments are determined by the CM. In CD-PSS, Client/Employers who adjust services [without the input of the CM] may be returned to 'traditional' EDWP services. Planning by the Client/Employer and CM is a critical element to successful consumer directed care.

NOTE: Medicaid will not reimburse for any CD-PSS services when the client is hospitalized or while he/she is a resident in a nursing facility.

Additionally, the Case Management instructs the employer/employer representative regarding process and documentation requirements. For procedures, see Section 1875 Employers/Employee Roles and Responsibilities.

1875 – EMPLOYER/EMPLOYEE ROLES AND RESPONSIBILITIES SUMMARY STATEMENT

Clients enrolled in the Traditional/ Enhanced EDWP and eligible to direct his or her personal support services must agree, in writing, to accept the role and responsibility of ***employer*** for

his/her caregiver employee. Individuals, appropriate for CDO but unable to independently direct his/her services, may select a representative to assume the employer role.

As employer, the client hires, schedules, instructs, disciplines, and terminates his/her direct care personal support staff. The client is the employer of record and must comply with all applicable labor rules required by the Georgia Department of Labor, federal and state tax laws, including unemployment taxes and Workman Compensation Insurance. Employers are responsible for managing their CDO budget and financial reporting.

Employees of consumer directed clients are encouraged to meet the qualifications recommended by the Georgia Department of Community Health.

BASIC CONSIDERATIONS

Prospective CDO employers/employer representatives receive two individualized employer trainings, provided by the Case Management. Upon completion of the training, employers will successfully learn and implement the following employer roles and responsibilities:

- Understand the required qualifications for their employee
- Develop employee job description(s)
- Develop criteria for employee selection
- Select a Georgia Medicaid waiver approved fiscal intermediary
- Recruit, hire and train, schedule and supervise employees
- Provide required documentation of employee qualifications to the fiscal intermediary (FI)
- Provide employee feedback at least quarterly
- Develop a back-up plan for service delivery
- Choose a Traditional/ Enhanced EDWP approved PSS provider agency as the state emergency back- up plan
- Create and maintain a positive and safe work environment
- Develop and preserve positive and effective professional boundaries
- Maintain spending with the budgeted limits of the individualized, comprehensive care plan
- Assure accuracy of employee time sheet compared to days/hours worked
- Approve and submit time sheets timely
- Understand Medicaid fraud

Clients, who need a representative to assume the role of employer representative, in the absence of a legal guardian or power of attorney, may choose an individual to serve in that capacity. Representative's maybe family members or friend, freely chosen by the client. Representatives will have knowledge of the client's care needs and preferences and demonstrate a strong personal commitment to assume the rights, risks and

responsibilities of directing the clients care.

Employers/Representatives receive no Medicaid reimbursement for participation or supervision in the Traditional/ Enhanced EDWP consumer direction option. An individual who serves in the role of employer representative may serve in that capacity for one (1) Traditional/ Enhanced EDWP client. A representative is not permitted to manage employer duties for multiple clients in the consumer direction option and the representative may not serve as direct care employees, nor can employees serve as employer representatives.

Employees, at minimum, are eighteen years of age, certified in Cardiac Pulmonary Resuscitation (CPR) and basic first aid, free of tuberculosis (TB), possess basic reading, writing and math skills, and demonstrate individualized experience, training, education and/or skills to assist the client. Direct care employees who assist with medication administration (proxy caregiver) are recommended to be trained and certified by a licensed health professional (physician, physician assistant, advance practice RN, RN or pharmacist) prior to providing assistance with medications and attend other training at the employer's request. Additionally, employees will comply with a criminal background check prior to employment and shall have no felony convictions, possess the physical ability to perform required tasks, acquire and maintain knowledge and understanding of the client's impairment(s) and condition(s) which limit performance of daily activities, comply with mandatory reporting of abuse, neglect and report and complete documentation related to and other incidents.

Employees will understand and agree to obey and fulfill Traditional/ Enhanced EDWP and CDO program requirements including but not limited to client rights and responsibilities and client confidentiality, annual medical checkups, maintenance of certifications, without lapse, and compliance with time sheet accuracy and reporting deadlines.

Paid staff in CDO are encouraged to adhere to best practices regarding the same professional standards and employment criteria as direct care employees working for a Traditional/ Enhanced EDWP personal support provider agency.

NOTE: Employees in consumer direction are not paid vacation benefits or holiday, premium pay.

All aides are paid at one and ½ times their normal hourly pay rate for any hours they work in excess of 40 during their 7 day work week. The FI will pay the rate for any overtime hours to the aide as it occurs from the member's available monthly budget. If all the money in the budget gets used up early because of the paid overtime, the employer will be responsible for paying the aide from their own money for the remainder of the month. The Case Management will NOT be authorized to increase the budget for the month.

NOTE: The live-in exemption is a valid exception to the rule. DCH should be notified

where this is applicable. Request this exemption through Case Management. DCH will authorize the exemption through the fiscal intermediary. To qualify, the worker must be paid at least minimum wage for all hours worked and the worker must permanently reside in the household where employed for 5 days a week (120 hours) or for 5 consecutive days and 4 nights or vice versa (for example, Monday mornings to Friday evenings).

As in the Traditional Enhanced / EDWP 'traditional' option of service delivery, Medicaid will not reimburse for any CD-PSS services when the client is hospitalized, in-patient in a hospice facility or a resident of a nursing facility. Individuals ineligible for employment in CDO include: legally responsible individuals (I.E. power of attorney, guardian), employer representatives, any individual with a history of abuse, neglect or exploitation and individuals who have committed criminal offenses which include but are not limited to the following:

- Murder or Felony Murder
- Attempted Murder
- Kidnapping
- Rape
- Armed Robbery
- Robbery
- Cruelty to Children
- Sexual Offenses
- Aggravated Assault
- Aggravated Battery
- Arson
- Theft by taking (O.C.G.A. 16-8-2), by deception (O.C.G.A. 16-8-3) or by conversion (O. C.G.A. 16-8-4
- Forgery (in the first or second degree)

PROCEDURES
Case Management provides individualized training to CDO employers utilizing the following:

- Employer Enrollment Packet (obtained from FI)
- Client Participation Agreement form
- Recruitment Strategies, Hiring and Conflict Mediation document
- Consumer-Directed Skills Inventory Checklist

IF	THEN
Client receiving PSS expresses desire and is appropriate for enrollment into CDO	Schedule a face to face visit with the client to review, clarify, provide definitions to the client and obtain client signature/consent on the Client Participation Agreement. Review employer processes- recruitment, hiring and conflict mediation
Client chooses CDO	Contact FI to request Employer Enrollment packet and confirms client receipt of the packet. CM schedules appointment to clarify any client questions (in person or by telephone)
Client completes enrollment packet	CM schedules in person visit to complete Skills Inventory/Training Check List and obtain signatures. The completed checklist documents all employers training and when completed, verifies that the client is willing and able to perform the role of client/employer. CM educates the client/employer about the use of the Employee Task List/time sheet/EVV system. See Part II-Chapter 1400 Policies and Procedures for EDWP (CCSP and SOURCE) Personal Support Services/Consumer Direction/Structured Family Caregiver 1405.

NOTE: Enrollment packets may be requested by telephone, electronic mail or may be downloaded from the FI website

Employer is responsible for financial management activities which include:

- Directing employees to complete the employment enrollment process with the FI and follow up with FI to ensure completion

- Completing the enrollment process with the FI prior to the employee's first day of employment

- Maintaining the employee personnel file which includes but is not limited to, copies of all employee time sheets, certifications, and training
- Reviewing and authenticating that employee timesheets reflect the actual time worked and submit to the FI by the date due

- Reviewing and monitoring budget and expenditures monthly

The employer is responsible for the completion and submission of the following documents to the FI:

- IRS Form 2678 – Employer Appointment of Agent form
- Consumer/Representative Employer Agreement form
- Authorization form
- Cost Share Agreement Form (if applicable)
- Durable Power of Attorney document (if applicable)

The employer assures each employee submits the following to the fiscal intermediary prior to hiring the employee:

- I-9 (Employment Eligibility Verification Form)
- W-4 (Employee Withholding Certificate)
- G-4 (State of Georgia Employee Withholding Allowance Certificate
- Important disclosure Form
- Pre-Employment Profile Form
- Authorization for Direct Deposit Form (optional)
- Employee rate information form
- Application for Employment
- Record Check Release form
- Consent for Release of information from DHS Aide and Abuse Registry [applies to Certified Nursing Assistants (CNA) only]
- Criminal Background Check-Release form
- Employee Information form

Hiring and all related functions of employment are assigned to the Employer/Employer Representative in Consumer Direction. Case Management has knowledge of employee eligibility and provide support and coaching to the employer when needed.

Employees are limited to one shift (twelve hours or less) within a twenty-four (24) hour period, with a forty- hour work week per pay period.

Employers determine the rate per hour. Employees are covered by Workman Compensation insurance as an FI requirement per Georgia Medicaid.

Employees are eligible for unemployment compensation through the Georgia Department of Labor; no health insurance benefits are provided by the employer.

Employers are permitted to hire non-relative direct care staff who meet all employment criteria.

Employees (proxy care givers) responsible for assisting clients with medication administration are recommended to be trained and certified by a licensed healthcare provider to verify the employee competence and understanding of medication route, side effects and treatment purpose.

NOTE: A member who can't perform their own blood sugar testing probably can't administer their own insulin, which also requires that an aide be trained as a proxy caregiver before they can assist.

Employees providing medication assistance and/or medication administration or health maintenance activities are recommended to meet the following minimum education standard: high school diploma or general education diploma (GED).

Employees already employed in Traditional/ Enhanced EDWP CDO who do not meet the minimum educational standard may be grandfathered in through a written statement signed by the employer and employee that the employer is aware of the employee level of education. This document must be filed in the employee personnel file in the employer's home.

Employees may be friends or neighbors.

Relatives are permitted to be employed as CD-PSS.

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NOTE: *Relative* is defined as a person who is related by blood within the third degree of consanguinity (including adoption) or by marriage. Third degree of consanguinity means mother, father, grandmother, grandfather, sister, brother, daughter, son, granddaughter, grandson, aunt, uncle, great aunt, great uncle, niece, nephew, grandniece, grandnephew, 1^{st} cousins, 1^{st} cousins, once removed and 2^{nd} cousins.

Refer to Part II- Chapter 1400 Policies and Procedures for EDWP (CCSP and SOURCE) Personal Support Services/Consumer Direction/Structured Family Caregiver Section 1404.3 regarding relative caregivers qualifications, experience, orientation, duties and training before the relative employee assumes the role of paid caregiver for the member; **Rev. 4/2023**

Members receiving traditional Personal Support Service, SFC or CD PSS service options can travel throughout the country/US and its territories. Prior notification to DCH and Case Management is required for time out of the home (member and aide

together) for vacation/family circumstance purposes. Traditional Personal Support and CD PSS will have to establish a schedule in the EVV system to be eligible for reimbursement. Providers are not responsible for travel costs. Out of Country travel with Medicaid is prohibited.

1876 – FISCAL INTERMEDIARY

SUMMARY STATEMENT

Financial Management Services or services provided by a Fiscal Intermediary is required to support the client/designated representative in the performance of employer duties for Consumer Directed Care.

BASIC CONSIDERATIONS

Fiscal Intermediary services are delivered by organizations/individuals enrolled as Medicaid providers through the Department of Community Health (DCH) and established as a legally recognized entity in the United States and registered to do business in the state of Georgia. Consumers have the choice to select a qualified provider within the criteria established by Department of Community Health.

The Financial Management Services/Fiscal Intermediary (FI) provider is responsible for the following:

- Consumer Enrollment
- Consumer-Employer Provider Services
- Payroll and Accounting
- Financial Management
- Cost Share Collection

<u>Consumer Enrollment activities:</u>

- Enroll consumers in FI and obtain authorization from the consumer or the representative
- Prepare and distribute application package of information for consumers hiring their own employees
- Provide needed counseling and technical assistance regarding the role of the FI to the consumer, representative and others

<u>Consumer-Employer Provider Services:</u>

- Process employment application package and documentation for

potential consumer-employed employee(s)

- Complete criminal background checks on potential consumer employees and maintain documentation

- Establish and maintain a record for each consumer employee and process all employment records

- Withhold, file and deposit FICA, FUTA and SUTA taxes and Workers Compensation insurance premiums in accordance with Federal IRS and state Department of Revenue rules and regulations

- Process all judgments, garnishments, tax levies or any related holds on any consumer employee as may be required by local, state or federal laws

- Generate and distribute IRS W-2 forms and/or other 1099 forms, Wages and Tax statements and related documentation annually to all consumer employees who meet the statutory threshold earnings amount during the tax year no later than January 31
- Withhold, file and deposit federal and state Department of Revenue Services rules and regulations

- Administer benefits for consumer employees on behalf of consumer

NOTE: The Fiscal Intermediary provides up to five (5) criminal background checks annually. Cost for additional criminal background checks are paid by the Employer.

Payroll and Accounting Activities:

- Act on behalf of the consumer/or representative receiving supports and services for the purpose of payroll reporting
- Distribute, collect and process all consumer employee time sheets as summarized on the payroll summary sheets completed and signed by the consumer or designated representative

- Prepare consumer employee payroll checks semi- monthly, sending them to the consumer, representative or directly to the consumer employee according to the service plan

- Generate payroll checks in a timely and accurate manner, as approved by the consumer's individual budget, and in compliance with all federal and state rules and regulations pertaining to "domestic service" workers (as defined by IRS)

NOTE: All CD PSS aides are paid at one and ½ times the normal hourly pay rate for any hours they work in excess of 40 during their 7-day work week. The pay for any overtime hours to the aide is paid as it occurs from the member's available monthly budget.

- Develop method of payment of invoices and Monitoring expenditures against the individual budget for each consumer and Case Management

- Receive, review and process all invoices from vendors and/or agencies providing services as approved in the consumer's budget authorized by the Case Management on the Service Order

- Generate monthly utilization reports for each consumer or representative, and Support Broker

NOTE: The FI does not process payroll deductions for health or other insurance benefits. Employees in need of health insurance may access from resource information available upon request from the FI.

Management Activities:

Establish and maintain all consumer records with confidentiality, accuracy and appropriate security safeguards

Respond timely to calls from consumers/representative

Respond timely to calls from employees regarding issues such as withholding, net payments, lost or late payroll checks, reports and other documents

File claims through Medicaid Management Information System (MMIS) for consumer-directed services and prepare consumer employee payroll checks

Generate service management and statistical information and reports

Providers of Financial Management Services assume responsibility for filing all claims related to CD-PSS, including PSS claims provided by provider agencies as emergency back-up. When emergency back-up services are used, the Employer is required to provide the FI with the following:

- Request for Emergency Back-up Agency Payment Form
- Emergency Back-up Agency Form

Provider agencies submit service records to the FI for reimbursement.

PROCEDURES

Employer and Employee financial document packets are provided by the fiscal intermediary. Packets are mailed upon telephone request by the Case Management /Support Broker. Contact the FI for questions about packet documents or other questions related to employer/employee financial management. FI services begin upon receipt of the Service Authorization Form (SAF) which verifies the client is eligible and approved for CD-PSS. All employer and employee paperwork is correctly completed and the Service authorization is generated and forwarded to the FI no later than the fifteenth of the month preceding participation in the consumer directed option. Consumer direction services are initiated on the first day of the month and may not be authorized for a partial month.

Service Authorization Form

Complete the SAF with 1 unit T2040 UC FI to authorize Medicaid reimbursement of the monthly FI fee to the Fiscal Intermediary provider. Use procedure code T1019 UC CD-PSS to authorize reimbursement of personal support services in consumer directed personal support services.

Upon receipt of the SAF, the FI processes the criminal back ground check and enters the employer and employee information into the payroll system. The FI notifies the Client/Employer of the background check results and the client begins participation in CD-PSS on the first day of the month.

NOTE: Employees may not provide services for participants in CD-PSS until the background check is complete and the employee is cleared for employment.

1877 – LEAD CASE MANAGEMENT

NOTE: The lead Case Management is employed by the Case Management Agency

Qualifications:

- If applicant is a RN/LPN, all qualifications reflected in the Traditional/ Enhanced EDWP Case Management team nurse job descriptions and a current license to practice in the State of Georgia.

- If applicant is not a nurse, all qualifications reflected in the Traditional/ Enhanced EDWP Case Management (social services) job description, and one year experience as a Traditional/ Enhanced EDWP social services Case Management and a bachelor's degree in a social service field.

General Description:

- Supervises Case Management personnel and/or acts as the liaison between Case

Management and the Executive Director.

Supervisory duties:

- Interprets policy and procedure.
- Provides or arranges initial training and orientation to new Case Management personnel.
- Provides or arranges in-service training for Case Management personnel.
- Represents Case Management at network meetings and other interagency meetings as directed by the Executive director of the case management agency.
- Serves as the contact person for lead agency staff, providers, Case Management and Department of Community Health
- Assures that case files and Case Management performances are reviewed as needed, or at a minimum that monthly supervisory staff conferences are held.
- May be assigned to monitor performance and prepare annual written performance evaluations of Case Management staff at the direction of the Executive Director.
- Arranges and participates in case conferences.
- Maintains current and appropriate personnel/training records.

Public Relations Duties:

- Collaborates with the lead agency in an assigned geographical area to educate the general public, health and social service agencies, physicians and other health professionals, nursing homes, hospitals, health providers, church and civic groups, etc., regarding the services available, and establishes credibility within the community.

Administrative Duties:

- Assures that statistical data is accurate, compiled and submitted on a regular basis in conjunction with Case Management team members.
- Assists in development and revision of policies and procedures.
- Attends organizational meetings and training as required.

- Keeps supervisor informed of Traditional/ Enhanced EDWP progress and problems.

Other Duties:

- Attends hearings as requested, providing data and client records required by the hearing officer.

- Collaborates with social services Case Management in development of the Comprehensive Care Plan.

- Refers clients in need of protective services to appropriate agency: APS Central Intake Unit if they live at home; LTCO and Healthcare Facility Regulation (HFC) if they are residents of an ALS/PCH facility.

- Refers clients not appropriate for Traditional/ Enhanced EDWP assessment to other services.

- Refers clients on the waiting list to other community resources to meet their needs.

- May or may not maintain a caseload according to agency policy/practice. If client caseload is maintained refer to appropriate job description based on qualifications.

- Maintains an updated Case Management Manual and Provider Services Manual.

- Consults with AAA, and/or DCH regarding policy interpretation, admitting clients when program is full, difficult cases, and client referrals made by DCH Commissioner's office.

- Completes certification to establish baseline quality performance standards. Certification curriculum will include online module performance testing. Topics will include waiver eligibility and program options, quality management requirements, case management roles and responsibilities and person-centered planning. New hires must complete training within 60 days from the hire date.

- Attends required participation at quarterly 'Train the Trainer' meetings or participates in review of the meetings with supervisors.

1878 CASE MANAGEMENT REGISTERED NURSE

NOTE: The RN is employed by the Case Management agency.

Qualifications:

Two years' experience as a registered professional nurse in one of the following areas:

- Geriatric nursing
- Community health
- Long term care
- Chronic diseases of adults.

NOTE: Completion of a course of study equivalent to a Master's degree in nursing, or community health may substitute for one year of experience.

General Description:

- Performs work of considerable difficulty in the professional assessment and determination of a level of care and appropriateness for community-based services for Medicaid recipients or potential Medical Assistance Only clients. Functions as a member of an interdisciplinary team including client's physician and serves large geographic areas which may include parts of one large county and/or many small counties which involve extensive travel. May supervise Case Management team at direction of ~~lead Case Management or~~ agency policy.

Supervisory duties as appropriate:

1. Provides RN supervision and clinical oversight to Licensed Practical Nurse Case Management
2. Refers to Case Management supervisory duties/Administrative under lead Case Management job description.

3. Reviews initial financial, medical, and social information of potential client as presented by referral source or the applicant.

4. Verifies DFCS Medicaid eligibility and/or screens for MAO/PMAO eligibility for using a standardized guideline.

Assessment/Reassessment Duties:

- Receives referral for initial Traditional/ Enhanced EDWP assessment from AAA/ADRC.

- Schedules appointment for face-to-face interview with prospective client at client's residence, hospital, long-term care facility, or other appropriate site as indicated.

- Conducts comprehensive interview with client and/or representative using intermediate level of care criteria and MDS-HC that allows for compilation of pertinent social information, functional status, physical, mental, nutritional status, adequacy/inadequacy of support system, and physical environment as well as the client's preference for community-based or institutional services.

- Reviews Medicaid eligibility and establishes approximate cost share, if indicated, using established guidelines.

- Explains to client and/or representative all aspects of the program and obtains client signature on all necessary forms.

- Analyzes and interprets all medical, social information as compiled, and obtains additional information as needed; e.g. consultation with physician and other professionals.

- Uses a comprehensive approach, to discuss and clarify client's needs in an inter-disciplinary team meeting.

- Determines with Case Management appropriate service and service setting necessary to maintain or improve the health/functional status of clients. Refers client/representative to non-Medicaid resources as available.

- Reviews all level of cares for Traditional/ Enhanced EDWP for uploading appropriate applicant documents to Alliant Health Solutions (AHS) while also making recommendations for denial if applicable.

- Signs all local level LOC denial letters and attends hearings as requested.

- Develops with Case Management an initial care plan.

- Completes a reassessment on clients following the appropriate guidelines.

- Approves reassessments completed by LPN Case Management.

- Collaborates with Provider RN to determine ECM/TCM eligibility.

- Coordinates disease management education and referral to physician and other healthcare providers to manage chronic disease.

Public Relations Duties:

- Collaborates with the lead agency in an assigned geographical area to educate the general public, health and social service agencies, physicians and other health professionals, nursing homes, hospitals, health providers, church and

civic groups, etc., regarding the services available.

Administrative Duties:

- Assists with statistical data compilation.
- Assists in development and revision of policies and procedures.
- Attends organizational meetings and training as required.
- Keeps supervisor informed of Traditional/ Enhanced EDWP progress and problems.

Other Duties:

- Attends Traditional/ Enhanced EDWP network meetings.
- Attends hearings as requested, providing data and client records required by the hearing officer.
- Collaborates with social services Case Management in development of the Comprehensive Care Plan including disease management, fall risk education and CM staff education.
- Refers clients in need of protective services to appropriate agency: APS Central Intake Unit if they live at home; LTCO and Healthcare Facility Regulation (HFC) if they are residents of an ALS/PCH facility.
- Refers client/representative to other services when not appropriate for Traditional/ Enhanced EDWP assessment.
- May maintain a caseload according to agency policy/practice.
- Maintains knowledge of Case Management Manual and Provider Services Manual.
- Completes certification to establish baseline quality performance standards. Certification curriculum will include online module performance testing. Topics will include waiver eligibility and program options, quality management requirements, case management roles and responsibilities and person-centered planning. New hires must complete training within 60 days from the hire date.
- Attends required participation at quarterly 'Train the Trainer' meetings or participates in review of the meetings with supervisors.

NOTE: The case management is employed by the Case Management Agency.

Qualifications:

A. Minimum Education and Experience

- Bachelor's degree in social work, sociology, psychology, or a related field, AND
- Two years experience in the human service or health related field.

B. Minimum Skill and Knowledge

- Ability to effectively coordinate and communicate with clients, service providers, general public, and other staff members
- Skill in establishing and sustaining interpersonal relationships
- Knowledge of human behavior, gerontology
- Skills in team building and group dynamics
- Knowledge of community organization and service system development
- Problem solving skills and techniques
- Knowledge and skill in social and health service intervention techniques and methodology.

General Description:

- Under direction, performs work of moderate difficulty by providing skilled casework services to selected caseloads or clients with special problems such as health disability or those at risk of nursing home placement; provides specialized casework services aimed at securing the client's overall well- being and maximum degree of independent functioning. Serves large geographic areas which may include one large county and/or many small counties which may involve extensive travel, and performs related work as required.

Social services Case Management's duties include the following:

NOTE: Lead Agencies may expand this list as appropriate based on local identified needs.

1. Reviews financial, medical, and social information of applicant as presented by referral source.

2. Verifies Medicaid eligibility and/or screens for MAO/PMAO eligibility, using standardized guidelines.

3. Explains thoroughly the scope and purpose of the Traditional/ Enhanced EDWP.

4. Identifies client's needs and desired services as stated by the referral source or applicant.

5. Determines if client is eligible for Traditional/ Enhanced EDWP and refers client to other appropriate resources.

Social Services Duties:

- Researches and maintains up-to-date knowledge of community resources.

- Participates in case conferences with the RN/LPN Case Management to discuss the plan of care as needed. Provides information on the availability of services, delivery options, and on the feasibility of implementing the service needs identified by the RN. In cooperation with the RN, determines the cost for implementing the plan of care for the client.

- Serves as the liaison between the assessment process and the effective delivery of direct services.

- Brokers the Traditional/ Enhanced EDWP services and implements the care plan.

- Arranges for non- Traditional/ Enhanced EDWP community-based services needed by the client.

- Notifies RN Case Management of any change in client status. Collaborates with RN re ECM/TCM changes that may influence eligibility.

- Monitors service delivery to individual clients to assure services are being provided as appropriate and effectively meets the client's needs.

- Continuously reviews, monitors, and updates the comprehensive care plan.

- Documents case activity and service information.

- Communicates and coordinates with all agencies providing direct services to the client.

- Approves/denies providers' requests for increased services based on the care plan and needs of the individual. Limits amount and frequency of service in order to assure that costs do not exceed the limitations established by the Department of Community Health

and the Department of Medical Assistance.

- Conducts personal contacts with each client monthly, by phone or quarterly site visits, in order to provide effective Case Management. Completes the 30 and 90- day CCP Review.

- Performs the monthly contact assessment in consultation with the client/caregiver.

- Develops the 30/90- day comprehensive care plan in consultation with the client, client's family and service providers.

- Reports suspected abuse, neglect, or exploitation of any client to APS if client does not live in a PCH, or to LTCO and ORS if client lives in a PCH. Reports information to the ALS family model provider, if appropriate.

- Arranges emergency services.

- Completes the Service Authorization Form (SAF). De-authorizes unused services timely.

- Monitors the expenditure of funds for Title XIX waivered services in the planning and service area, in cooperation with the lead agency.

- Sends/uploads necessary information to county DFCS office/Gateway System when LOC returned and services begin.

- Communicates with DFCS/uploads to Gateway regarding MAO/PMAO eligibility.

- Maintains confidential case records on all Traditional/ Enhanced EDWP clients.

- Requests redetermination of the client's level of care prior to its expiration or if there is a change of status, new services required.

- Advocates for the special needs of the functionally impaired population requiring community based services.

- Maintains knowledge of the provider service standards for each Traditional/ Enhanced EDWP service.

- Assists clients with appeals and attends hearings. Provides data and client records required by hearing officer as required.

- Attends Traditional/ Enhanced EDWP Network meetings and other meetings coordinated by AAA.

Public Relations Duties:

- Collaborates with the lead agency in an assigned geographical area to educate the general public, health and social service agencies, physicians and other health professionals, nursing homes, hospitals, health providers, church and civic groups, etc., regarding the services available.

Administrative Duties:

- Meets with supervisor at least monthly to discuss and review cases.
- Compiles and submits to supervisor statistical data on a regular basis.
- Assists in development and revision of policies and procedures.
- Attends organizational meetings, and training as required.
- Keeps supervisor informed of progress and problems associated with duties.
- Maintains knowledge of Case Management Manual and Provider Services Manual and revisions.
- Performs other duties as assigned
- Completes certification to establish baseline quality performance standards. Certification curriculum will include online module performance testing. Topics will include waiver eligibility and program options, quality management requirements, case management roles and responsibilities and person-centered planning. New hires must complete training within 60 days from the hire date.
- Attends required participation at quarterly 'Train the Trainer' meetings or participates in review of the meetings with supervisors.

1880 – Traditional/ Enhanced EDWP ADRC SCREENING SPECIALIST

NOTE: The Traditional/ Enhanced EDWP screening specialist is employed by the AAA.

Qualifications:

- If an applicant is a nurse, all qualifications reflected in the Traditional/ Enhanced EDWP Case Management registered nurse and licensed practical nurse job descriptions and a current license to practice in the State of Georgia.

- If an applicant is not a nurse, all qualifications reflected in the Traditional/ Enhanced EDWP Case Management (social services) job description, and/or one- year experience as a Traditional/ Enhanced EDWP social services Case Management and a bachelor's degree in a social service field.

NOTE: The AAA must hire at least one registered nurse to review ADRC screening decisions.

General Description:

Acts as first point of contact for individuals requesting services from the Traditional/ Enhanced EDWP, either for themselves or someone else.

Screening Duties:

- Screens referrals within five business days of receipt.
- Accepts and screens all referrals from individuals wishing to participate in the Traditional/ Enhanced EDWP.
- Conducts a telephone screening, completes the DON-R, and determines applicant priority for full assessment.
- Reviews potential Medicaid eligibility for Traditional/ Enhanced EDWP.
- Identifies applicant needs and service requests as stated by referral source.
- Notifies the potential applicant/referral source of referral status.
- Informs ineligible applicants of the right to appeal.
- When appropriate, refers applicant for other available services.
- Determines if the applicant is eligible for Traditional/ Enhanced EDWP and refers individuals on the waiting list to other appropriate resources.

1881 CASE MANAGEMENT LICENSED PRACTICAL NURSE

NOTE: The LPN is employed by the Case Management Agency.

Qualifications:

A. Currently licensed to practice in the State of Georgia and two years' experience as a licensed practical nurse (LPN) in one of the following areas:

- Geriatric nursing
- Community health
- Long term care
- Chronic diseases of adults

NOTE: Completion of a course of study equivalent to a Bachelor's degree in human services, community health or Gerontology may substitute for one year of experience.

B. Minimum Skill and Knowledge

- Ability to effectively coordinate and communicate with clients, service providers, general public, and other staff members
- Skill in establishing and sustaining interpersonal relationships
- Knowledge of human behavior, gerontology
- Skills in team building and group dynamics
- Knowledge of community organization and service system development
- Problem solving skills and techniques
- Knowledge and skill in social and health service intervention techniques and methodology.

General Description:

- Under direction and supervision of a licensed, professional registered nurse, performs medical and social assessment of nursing facility intermediate level of care and appropriateness for community-based services for Medicaid recipients.
- Completes assessments on clients following appropriate guidelines and submits all assessments to a registered nurse for review and approval. LPN makes corrections and additions as recommended by supervising RN. Under supervision of a licensed professional registered nurse, the LPN functions as a member of an interdisciplinary team including client's physician and serves large geographic areas which may include parts of one large county and/or many small counties which involve extensive travel.
-

Assessment Duties:

1. Schedules appointment for face-to-face interview with prospective client at his or

her residence, hospital, long-term care facility, or other appropriate site as indicated.

2. Conducts assessments in a face to face interview with the client and/or representative using the intermediate level of care criteria and the MDS-HC. Collaborates with RN re ECM/TCM changes that may influence eligibility.

3. Develops the Comprehensive Care Plan to reduce the risks identified in the MDS-HC triggers.

4. Submits completed assessments to the registered nurse supervisor for review and recommendations of approval or denial. LPN completes any recommended corrections prior to submitting the assessment packet to the RN for approval/denial review and applicable submission to Alliant Health Solutions (AHS) and the client's physician.

5. Reviews changes in CCP with assigned Case Management.

6. Analyzes and interprets all medical, social information as compiled, and obtains additional information as needed: e.g. consultation with RN supervisor, physician and other professionals.

NOTE: Lead Agencies may expand this list as appropriate based on local identified needs.

Administrative Duties:

- Assists with statistical data compilation.
- Attends organizational meetings and training as required.
- Keeps supervisor informed of Traditional/ Enhanced EDWP progress and problems.

Other Duties:

- Attends Traditional/ Enhanced EDWP network meetings.
- Attends hearings as requested, providing data and client records required by the hearing officer
- Performs the monthly contact assessment in consultation with the client/caregiver if applicable for that Case Management agency.
- Develops the 30/90- day comprehensive care plan in consultation with the client, client's family and service providers if applicable for that Case Management agency.
- Communicates with DFCS/uploads to Gateway regarding MAO/PMAO eligibility.
- Collaborates with RN supervisor and/or social services Case Management in

development of the Comprehensive Care Plan.

- Participates in interventions identified in the client's disease management plan.
- Refers clients in need of protective services to appropriate agency: APS Central Intake Unit if they live at home; LTCO and Healthcare Facility Regulation (HFC) if they are residents of an ALS/PCH facility.
- Refers client/family to other non-Medicaid services as appropriate/available to meet client needs.
- Maintains knowledge of Case Management Manual and Provider Services Manual.
- May maintain a caseload according to agency policy/practice.
- Completes certification to establish baseline quality performance standards. Certification curriculum will include online module performance testing. Topics will include waiver eligibility and program options, quality management requirements, case management roles and responsibilities and person-centered planning. New hires must complete training within 60 days from the hire date.
- Attends required participation at quarterly 'Train the Trainer' meetings or participates in review of the meetings with supervisors.

NOTE: Licensed Practical Nurse Case Management responsible for carrying a caseload are responsible for all activities performed by Social Service Case Management.

1882 Introduction to SOURCE

SOURCE operates under authority of the Elderly and Disabled 1915-c Home and Community Based Services (HCBSS) Medicaid Waiver approved by the Centers for Medicare and Medicaid Services (CMS).

Individuals eligible for enrollment in SOURCE must be eligible for full Medicaid (this excludes SLMB, QMB, and QI). Individuals served by SOURCE must be physically **impaired**, functionally impaired and in need of services to assist with the performance of activities of daily living (ADLs). Without waiver services, eligible SOURCE members would require placement in a nursing facility. While individuals, participating in SOURCE under the Elderly and Disabled waiver, do not have specific exclusions related to age, the SOURCE waiver targets individuals who are elderly and physically disabled.

Through the Enhanced Primary Care Case Management (EPCCM) model, SOURCE links primary care to community services. The model is comprised of three principal components – primary medical care, community services and case management -integrated by the site's authority to approve Medicaid-reimbursed services.

SOURCE sites receive an enhanced case management fee per member per month.

Community and physician services for SOURCE members are covered under conventional Medicaid fee-for-service reimbursement with authorization by the site. For dually insured members, Medicare remains the primary payer for services traditionally covered by Medicare. While the SOURCE Case Management Provider is expected to coordinate services delivered under Medicare, no authorization is required for Medicare reimbursement. For services covered by Medicaid, in addition to community and physician services (hospitalizations, lab/diagnostics, co-pays for dually insured members, etc.), the SOURCE Enhanced Case Management authorization number may be required.

SOURCE Goals

Goals identified for SOURCE include:

a) Reducing the need for long-term institutional placement and increasing options in the community for older and disabled Georgians, by designing an effective model replicable across the state

b) Preventing the level of disability and disease from increasing in members with chronic illness

c) Eliminating fragmented service delivery through coordination of medical and long-term support services

d) Increasing the cost-efficiency and value of Medicaid Long Term Care (LTC) funds by reducing inappropriate emergency room use, multiple hospitalizations and nursing home placement caused by preventable medical complications; also by promoting self-care and informal support when possible for individual members

Core Refinements to Traditional HCBS

The SOURCE Program implements three (3) core refinements to traditional HCBS programs:

1) SOURCE financially and operationally integrates primary medical care with the case management of home and community-based services.

2) SOURCE develops individualized Care Plans for chronically ill persons (targeting conditions such as diabetes, high blood pressure, Alzheimer's Disease, dementia, stroke, heart disease, asthma or other pulmonary conditions) Care Plans constitute a structured case management accountability system that regularly measures the achievement of key objectives for individual members, for the caseload of each Case Manager or Primary Care Provider and for the entire program.

3) SOURCE measures the performance of Case Management Agencies and providers of community services by standards that exceed basic licensing requirements. Case Management Agencies and Providers of personal/extended support services (the most highly accessed category of service) will honor member and program expectations of:

Reliability of service, including early morning or late evening visits/care Adequate, Competent, Consistent, Compatible staffing

Responsiveness to member and staff concerns, including the scope of care as described by the member or caregiver

Coordination --with Case Managers for the community service providers and Other Agencies for the Case Management Agencies

The Case Management and provider's role in achieving care plan objectives – including member satisfaction with services – is regularly measured, addressed with performance improvement strategies as indicated and used to determine case assignments.

SOURCE Themes

The SOURCE vision of an ethical and disciplined community-based long-term care system is described by several key themes that apply broadly to all members in the program (sites, members, providers, DMA):

Integration:

Empowerment via the authority to enforce expectations of key players by authorizing payments
Communication – scheduled and as needed to meet individual and program goals
Common objectives that keep members at the center

Member centered approach:

Member/family contribution and cooperation encouraged and valued
Advocacy for individual members, across all settings
Inclusiveness of varying ages, disabilities and functional capacities

Continuous improvement:

Collecting and reviewing data regularly to identify problem areas
Marshalling resources to help individuals address problems
Redesigning systems to help DCH address problems for chronic care populations

Partnership with DCH

All sites will maintain a partnership with DCH to continuously improve overall program performance and to ensure that individual sites are working toward stated goals.

This partnership may be fulfilled by sites in several ways**:**

a) Participation at scheduled meetings with DCH staff to discuss program guidelines, performance improvement strategies and site-specific updates.
b) Monthly reporting to DCH on program activity due on the 15th of the month following the reporting period

c) Compliance with quality assurance protocols for waiver programs developed for CMS by DCH

DCH maintains oversight of all program components and reserves the right to grant final approval of all aspects of the program including, but not limited to, determination of eligibility and ILOC.

1883 Eligible Members

SOURCE operates undue the authority of the Georgia Elderly and Disabled 1915c Medicaid Waver. For core waiver requirements see section 1884.

The target population for SOURCE are physically disabled individuals who are functionally impaired, or who have acquired a cognitive loss, that results in the need for assistance in the performance of the activities of daily living (ADLs) and instrumental activities of daily living (IADLs); these individuals must meet the Definition for Intermediate Nursing Home Level of Care (LOC). Eligibility factors must be met annually or more often per guidelines in this manual, referenced manuals and the federal Waiver.

a) Aged 65 and older, or under 65 and physically disabled
b) Receiving full Medicaid (this excludes SLMB, QMB, QI)
c) Eligible based on meeting criteria for Intermediate Nursing Home Level of Care
d) Cost of necessary services can be provided by SOURCE at less cost than the Medicaid cost of nursing facility care
e) Willing participants who choose enrollment in the SOURCE Program (Member choice)
f) Residing in a SOURCE Enhanced Case Management's designated service area; and
g) Capable, with assistance from SOURCE and/or informal caregivers, of safely residing in the community (with consideration for a recipient's right to take calculated risks in how and where he or she lives) calculated risks in how and where he or she lives)

Note: Home Delivered Meals and Case Management combined is not the only service need

NOTE: Medicaid eligible members under the age of twenty-one (21) will be referred to Medicaid's GAPP (Georgia Pediatric Program) to be screened for the Medicaid's State Plan services. Any service request for those under 21 that is not covered in the State Plan under GAPP or Autism Spectrum Disorder Services can be referred for screening and eligibility determination of the requested service. As the Department moves to evaluate children on the waiver and compliance with federal mandates, continuity of care will be the first concern.

Member General Exclusions

- Members currently enrolled as members in the Georgia Families program (this is

not the Georgia 360 program)

- Members with retroactive eligibility only and members with presumptive eligibility
- Children with severe emotional disturbances whose care is coordinated under the PRTF program
- Members of a federally- recognized Indian Tribe
- Qualified Medicare Beneficiaries (QMBs) without SSI (or full Medicaid);
- SLMB or QI without SSI (or full Medicaid)
- Members Residing in an Institution
- Members not meeting eligibility requirements
- Programs or Waivers that would cause duplication or services*

Allowances

SOURCE dual enrollment in Hospice may be permitted without duplication of services.

An individual currently enrolled in a Medicaid waiver program that is diagnosed with a terminal illness may elect to enroll in the Hospice program. Please see the EDWP General Manual section 901 Covered Services for more information.

Procedure for Dual Enrollment:

If dual enrollment is desired by the member and meets the guidelines above (and of course all eligibility requirements) the agency should follow these procedures:

A. The member's SOURCE team and the 2nd program's case manager and member **must** communicate, establish, and agree upon a coordinated plan of care for both providers that prevents duplication of services. Distinct Case management services must be agreed upon to be given by each CM agency. Information on these areas is documented at the beginning of the relationship and quarterly. More frequent communication should be documented if the need arises.

B. Both companies must keep records that indicate that multiple Medicaid plans of care have been coordinated. Failure to demonstrate this coordination will be considered a failure to comply with the terms of this policy. As such, lack of evidence of coordinated care in documentation will result in a terminated lock-in and any paid claims for services will be subject to recoupment.

C. If Hospice is the designated 2nd program, the hospice agency MUST be the provider of the skilled nursing and personal support services. SOURCE may provide extended personal support services (in-home respite). If SOURCE member

is in a PCH, the PCH must continue to give all care and not designate the normal care of a member to the Waiver such as hospice

D. All hospice services must continue to be provided directly by hospice employees. The services cannot be delegated. When the member is in a waiver program residential facility (SOURCE Personal Care Home), the hospice agency may involve the facility staff in assisting the administration of prescribed therapies that are included in the plan of care; this is only to the extent that the hospice would routinely utilize the service of the patient's family/caregiver in implementing the plan of care.

E. When the member is a resident in a waiver program's residential facility, the facility must continue to offer the same services to the individual that elects the hospice benefit. The hospice member should not experience any lack of facility services because of his/her status as a hospice member.

F. The member's EDWP team and the hospice program's case manager and member must communicate, establish, and agree upon a coordinated plan of care for both providers that prevents duplication of services. Distinct Case management services must be agreed upon to be given by each agency. **Information on these areas is documented at the beginning of the relationship and <u>quarterly</u>, both in the assessment and case note is recommended. More frequent communication should be documented if the need arises**]. Hospice must be a part of the discussion and coordination with hospice should be documented whenever the plan of care is modified, even if more often than quarterly.

While attempts to coordinate cannot be forced, attempts to coordinate care should be thoroughly documented. Attempted contacts in notes and assessments is evidence of good faith effort to comply with the coordination of care requirement, keeping fax cover sheets and fax confirmation print outs, log any phone calls or voicemails, and document any mailings and delivery confirmations. Similarly, any coordination-related changes to the plan of care should be documented clearly. For example, if a patient enters hospice and their Emergency Response Service is discontinued because of that hospice admission, the case manager may document to "suspend ERS effective April 1, 2023 – patient instructed to call the hospice on-call nurse line for emergencies." This shows that the case manager is actively incorporating hospice into their care planning, even though their attempts to contact hospice were not successful.

The following activities are not allowed by SOURCE providers of any type:

SOLICITATION OF MEMBERS FOR THE SOURCE PROGRAM
This includes:

- Developing care plans, using amount or frequency of services, to encourage member choice of providers
- Soliciting clients from other providers or other programs

Neither SOURCE case management providers nor HBCS providers shall solicit Medicaid members for the purpose of rendering SOURCE services, following the policy outlined in: Part I, Policies and Procedures for Medicaid/Peachcare for Kids-- which all Medicaid providers
agree to follow. The policy states:

106. General Conditions of Participation

Not contact, provide gratuities or advertise "free" services to Medicaid or PeachCare for Kids members for the purpose of soliciting members' requests for services. Any activity such as obtaining a list of Medicaid or PeachCare for Kids members or canvassing neighborhoods (or offices) for direct contact with Medicaid or PeachCare for Kids members is prohibited. Any offer or payment of remuneration, whether direct, indirect, overt, covert, in cash or in kind, in return for the referral of a Medicaid or PeachCare for Kids member is also prohibited. It is not the intent of this provision to interfere with the normal pattern of quality medical care that results in follow-up treatment. Direct contact of patients for follow-up visits is not considered solicitation, nor is an acknowledgment that the provider accepts Medicaid/PeachCare for Kids patients.

1884 Levels of Care

Level of Care Criteria

a) The Intermediate Level of Care (LOC) determination for SOURCE is based on: the medical criteria used by Department of Community Health (DCH), Division of Medicaid to establish an individual's LOC certification for nursing facility placement. SOURCE members must meet the Level of Care criteria for Intermediate Nursing Home Placement (see 1884). Level of care determination is a function of the assessment process which includes: the SOURCE RN/LPN, using the MDS-HC (v-9), Level of Care criteria, and professional judgment, giving a preliminary determination of Level of Care (LOC) for members during the assessment process.

b) AHS or DCH gives final approval on all members for an active Level of Care. The level of care medical review team may request and/or retrieve additional medical information for the purpose of determining eligibility. Information may include hospitalization information, medical equipment needs, previous treatment and medical history. 10/2023

c) Assessments and re-assessments completed by the LPN **must** be signed and certified by the designated RN within 10 business days of completion.

d) SOURCE services rendered to a member will be ordered by a physician and listed on the Care plan and SOURCE Level of Care and Placement Instrument with the Primary Care Physician/Medical Director's signature on the orders.

e) Providers may render SOURCE Services only to members with a current LOC as reflected on current SOURCE Level of Care and Placement Instrument, approved by AHS (all members as of 9/30/2013), and affirmed by the completed MDS-HC (v9) assessment.

f) Members must meet all SOURCE eligibility criteria to participate in the program.

g) Each qualifying SOURCE member is given an approved LOC certification for SOURCE program participation by AHS. A LOC certification is approved for no more than 12 months (usually 365 days).

h) The AHS Prior Authorization effective date is to be the LOS start date on the SOURCE Level of Care and Placement Instrument LOC form, the AHS expiration date is to be the LOS end date.

i) Effective with SOURCE Initial Assessments conducted on March 1,2018 or after, the approved length of stay will begin with the day the assessment is conducted. This will allow case management to be covered under a length of stay for a level of care from the date of the assessment. This cannot be billed until the Level of Care has been determined by AHS and attestation of the Medical Director and RN.

Note: DCH maintains oversight of all program components and reserves the right to give final approval on all aspects of the program including eligibility and ILOC. DCH may extend LOC with legal documents or provisional level of care document. This may be especially necessary during the months when transitioning from MMIS locks to Prior Approval system.

COLUMN A	COLUMN B	COLUMN C
Medical Status	Mental Status (must include a cognitive loss) rev. 04/11 Mental Status impairment with etiologic diagnosis not related to a developmental disability or mental illness The mental status must be such that the cognitive loss is more	Functional Status impairment with etiologic diagnosis not related to a developmental disability or mental illness

For Source, the eligible individual will meet the target population guidelines and Intermediate Nursing Home LOC:
The target population for SOURCE is physically disabled individuals who are functionally impaired or who have acquired a cognitive loss that results in need of services to assist with the performance of the activities of daily living (ADLs). All individuals must meet the Definition for Intermediate Nursing Home LEVEL OF CARE:

Summary for Intermediate Nursing home LEVEL OF CARE CRITERIA and SOURCE Program guidelines:

1. Services may be provided to an individual with a stable medical condition requiring intermittent skilled nursing services under the direction of a licensed physician (Column A Medical Status) AND either a mental/ cognitive (column B) and/or functional impairment that would prevent self-execution of the required nursing care (Column C Functional Status).

2. Special attention should be given to cases where psychiatric treatment is involved. A patient is not considered appropriate for intermediate care services when the primary diagnosis or the primary needs of the patient are psychiatric or related to a developmental disability rather than medical need. This individual must also have medical care needs that meet the criteria for intermediate care facility placement. In some cases, a patient suffering from mental illness may need the type of services which constitute intermediate care because the mental condition is secondary to another more acute medical disorder.

Use the following table to assist with SOURCE Level of Care and Placement Instrument and I for SOURCE clients:

To meet an intermediate nursing home level of care the individual must meet item # 1 in Column A AND one other item in Column A, PLUS at least one item from Column B or C (with the exception of #5, Column C)

Items are interpretive guidelines for SOURCE eligibility.

1. Requires monitoring and overall management of a medical condition(s) under the direction of a licensed physician. In addition to the criteria listed immediately above, the patient's specific medical condition must require any of the following (2-8), plus one item from Column B or C. 2. Nutritional management; which may include therapeutic diets or maintenance of hydration status. 3. Maintenance and preventive skin care and treatment of skin conditions, such as cuts, abrasions, or healing decubiti. 4. Catheter care such as catheter change and irrigation. 5. Therapy services such as oxygen therapy, physical therapy, speech therapy, occupational therapy (less than five (5) times weekly for SOURCE). 6. Restorative nursing services such as range of motion exercises and bowel and bladder training. 7. Monitoring of vital signs and laboratory studies or weights. 8. Management and administration of medications including injections.	1. Documented short or long-term memory deficits with etiologic diagnosis such that it interferes significantly with the activities of daily living. Cognitive loss must also be addressed on MDS/care plan for continued placement. 2. Documented moderately or severely impaired cognitive skills with etiologic diagnosis as above for daily decision making such that it interferes significantly with the activities of daily living. Cognitive loss addressed on MDS/care plan for continued placement. 3. Problem behavior, i.e., wandering, verbal abuse, physically and/or socially disruptive or inappropriate behavior requiring appropriate supervision or intervention such that it interferes significantly with the activities of daily living. Cognitive loss must also be addressed. 4. Undetermined cognitive patterns which cannot be assessed by a mental status exam, for example, due to aphasia such that it interferes significantly with the activities of daily living. Cognitive loss must also be addressed.	1. Transfer and locomotion performance of resident requires limited/extensive assistance by staff through help or one-person physical assist. 2. Assistance with feeding. Continuous stand-by supervision, encouragement or cueing required and set-up help of meals. 3. Requires direct assistance of another person to maintain continence. 4. Documented communication deficits in making self- understood or understanding others. Deficits must be addressed in medical record with etiologic diagnosis addressed on MDS/care plan for continued placement. 5. Direct stand-by supervision or cueing with one-person physical assistance from staff to complete dressing and personal hygiene. (If this is the only evaluation of care identified, another deficit in functional status is required).

PROCEDURES ONCE 'SLOT' IS AVAILABLE FOR MEMBER:

1) Complete MDS-HC with member
2) Obtain member signature on the SOURCE Level of Care and Placement Form
3) Upload required material requested by AHS to AHS via web portal.

4) If AHS validates Level of Care then give the entire packet to the multidisciplinary team meeting with the Medical Director who will sign

Primary Medical Care

SOURCE Case Management Provider Case Managers work with member's primary care provider on meeting program goals for members. Providers include physicians, (e.g. Internal Medicine, Family Practice and geriatricians), and nurse practitioners.
In addition to traditional functions of evaluation/ treatment for episodic illness and minor injury, key features of SOURCE primary care are:

Initial visit upon enrollment, unless member is already under the care of their Primary Care Provider prior to enrollment.

Chronic disease management, including the use of the EDWP Enhanced Case Management Physician Letter twice a year

Communication with Case Managers as needed.

Reliance by Primary Care Provider on case management staff for information by way of the EDWP Enhanced Case Management Letter regarding:

- Care Plan variances
- Home environment
- Informal support
- Community services

Case management role includes assisting members in carrying out Primary Care Physician orders and interventions

Referral, coordination and authorization for specialists, hospitalizations, home health and Ancillary services.

Wellness promotion and preventive health measures, including immunizations, cancer screenings, vision and hearing screenings, etc.

Site Medical Director

The Site Medical Director occupies a unique position of influence in local perceptions of Community Based Long-Term Care. The Medical Director may also be a Nurse Practitioner, or a Physician Assistant working under the direction of a medical doctor. A copy of the supervising physician must be kept in office. The Medical Director will ideally have a strong history and connection with the local medical community, facilitating understanding of the model and fostering support for member and program goals. The Medical Director will participate actively on the site's multidisciplinary team and will advocate on behalf of the program or individual member with the local health system or other physicians.
Specific responsibilities of the Medical Director include working with the multi-disciplinary team to:

a) Advise on the local site's policies/procedures.
b) Advise on the local site's internal grievances.
c) Advocate on behalf of the program or individual member with the local health system(s), and community physicians
d) Confirm the services ordered, signing the SOURCE Level of Care and Placement Instrument form for new members, and reassessments.
e) Any recommendation made by the Medical Direction will be conveyed to the primary care physician by Case Manager using the Physician Disease Management Letter sent bi-annually.

Program sites may ask their Medical Director to assist in problem solving on behalf of the member such as chronic non-compliance, repeat hospital encounters, and complex cases are needed.

Case Management

Case Management is a collaborative process which includes assessing, implementing, coordinating, monitoring, evaluating options and services required to meet individual needs and making referrals as needed. SOURCE case managers may consist of nurses, RN and LPN, currently licensed in Georgia and social workers. Starting July 1, 2019, all new hires for case management will be RN or LPN licensed in Georgia, or a social worker with a bachelor's degree in social work or comparable field.

The four components of case management are described as follows:

- Assessment and periodic reassessment – determine service needs, including activities that focus on needs identification, to determine the need for any medical, educational, social, or other services. Assessments are comprehensive in nature and should address all needs of the individual, including an individual's strengths and preferences, and consider the individual's physical and social environment.

- Development and periodic revision of the Care Plan – specifies the goals and actions to address the medical, social, educational, and other services needed by the eligible individual, as collected through an assessment or reassessment.

- Referral and related activities – help an individual obtain needed services, including activities that help link eligible individuals with medical, social, educational providers, or other programs and services that are capable of providing needed services to address identified needs.

- Monitoring and follow-up activities – include activities and contacts that are necessary to ensure that the care plan is effectively implemented and adequately addresses the needs of the eligible individual. These activities should take place at least on a quarterly basis for face to face contacts and at least monthly for phone contacts. The monitoring and follow-up activity determine whether the services are being furnished in accordance with the individual's care plan; services are adequate to meet the needs of the individual; and there are changes in the needs or status of the individual.

See 106 (LL) Part I Policies and Procedures for Medicaid/Peachcare for Kids Policy Manual to maintain compliance with background screening requirements for fingerprint/criminal background checks of owners, administrators, onsite managers, directors, and direct access employees.

SOURCE CASE MANAGEMENT TEAM

Each SOURCE Enhanced Case Management Team convenes a formal multidisciplinary team meeting weekly, bi-weekly, or monthly as needed to perform the following functions:

a) Review new admissions and discuss the need for Home and Community Based Services. Discuss the cost of the service plan and sign the level of care if in agreement with the plan.
b) Review annual renewals of level of care and sign if in agreement with the service plan.
c) Review service plan changes and signing the change of service letters.
d) Hear issues of non-compliance and involuntary discharge and advise as needed.

At a minimum, membership on the team will include: Medical Director, Case Management Supervisory Staff, an RN/LPN and Case Manager presenting new members or information. As needed other clinical, case management or administrative staff members may participate in the team meeting. At the team meetings, the **member's initial assessment, annual re-assessments, and Modified Assessments will be reviewed. The Medical Director's signature on the EDWP Level of Care and Placement Instrument form will be required at the meeting. RN must sign on the next business day of the Medical Director's signature.**

Community Services Providers

All community services providers must first be enrolled under CCSP and must comply with CCSP policies and procedures unless indicated otherwise in this manual. As of July 1st, 2013, SOURCE opened enrollment to all current CCSP HCBS providers in good standing. Providers will need to enroll in SOURCE per directions found in section 608. Compliance with increased performance expectations is expected for all SOURCE providers to achieve optimal health states for SOURCE members. SOURCE emphasizes the provider role in achieving outcomes associated with community residence and optimal health status for SOURCE members. This is accomplished by working closely with the Care Management agency and remaining compliant with current policy. When contacted by the SOURCE Case Management Agency and a client is brokered, the provider must abide by all SOURCE rules and conditions, including maintaining current on CCSP policy.

Reimbursed services through SOURCE are:

Personal Support Services/Extended Personal Support (PSS/EPS)
Consumer Directed Option PSS
Structured Family Caregiving (Required completion of the Appendix D)
Adult Day Health (ADH)
Home Delivered Meals (HDM)

Alternative Living Services (ALS)
Emergency Response System (ERS)
Home Delivered Services (HDS)
Skilled Nursing Services (SNS) (only used when all other home health agency options have been exhausted, ref. chapter 1900 of EDWP Manual)

Community services primarily offer assistance to members in activities of daily living (ADLs) and instrumental activities of daily living (IADLs). Self-care and informal sources are first maximized before accessing HCBS in SOURCE. The CCSP/SOURCE provider manuals may be referenced for definitions of these service categories. Unless otherwise noted in this document, Community service providers will operate in accordance with EDWP provider-specific manuals. Copies of EDWP provider-specific manuals are available through the Gainwell Technologies Website: www.mmis.georgia.gov

Key characteristics of the SOURCE provider role (and used for provider compliance):

a) Intensified communication/coordination with case management staff, over conventional HCBS programs

b) Commitment to continued service for members with challenging personal situations or diagnoses

c) Demonstrated efforts to serve manpower shortage areas

d) Service for members needing PSS/EPS hours both above traditional service levels and below

e) Willingness to flex service levels as authorized by Case Manager, in response to the complex or unpredictable status of individual members

f) Customer satisfaction standards exceeding basic licensing requirements; specific areas of accountability include:
Reliability of service, including early morning or late evening visits
Competency, compatibility, and consistency of staffing
Responsiveness to member and staff concerns, including the scope of care as described by the member or caregiver
Coordination with Case Manager

g) Regular measurement of performance

h) Complaint Log for providers will be maintained on those that clients have continuous issues with.

i) An active 24-hour on-call service that coordinates dependably with Case Manager and member's Provider and Caregiver

1885 SCREENING

Potential SOURCE members will be screened to determine likely eligibility using the Determination of Need – Revised (DON-R) screening tool. The tool was designed and

validated for use in telephonic screening and provides a method for prioritizing SOURCE applicants for admission. SOURCE screening is performed by the SOURCE Enhanced Case Management agencies, usually at the time of applicant inquiry by telephone. Screening is conducted by phone or can be conducted face to face in the case of difficult to screen individuals (those with communication impairment, no telephone, or cognitive impairment). Referrals may come from many sources, including but not limited to:

a) Hospital discharge planners
b) Physician offices
c) Family members or other informal caregivers
d) Community social service agencies
e) Home health agencies or other health system organizations
f) HCBS Service Providers

Procedures:

Inquiries will be documented using the DON-R tool along with the SOURCE screening form used for collection of demographic data.

Medicaid Eligibility: Screening staff will access the GAMMIS website to confirm a potential member's eligibility status. For persons not eligible for SOURCE or not interested in joining the program, appropriate referrals to other services or organizations will be made (including referral to the Social Security Administration if the person screened may be eligible for SSI). See also Policy No. 1405, Right to Appeal.

Functional Eligibility: Full screening is completed within three business days of the initial inquiry. Extenuating circumstances which prevent meeting the standard of promptness will be documented on the Screening Form. All telephone screening is only considered complete when performed using the Determination of Need – Revised assessment tool.

The use of Interpreters is necessary to ensure members are ESL (English as Second Language) are understood in their native language and conflict free case management standards are maintained.

NOTE:
EDWP applicant screening performed by Case Management for SOURCE and the Area Agency on Aging for CCSP as well as monthly contact call policy requirements for Case Managment are to utilize a camera telehealth modality encrypted (end to end encryption) software product with established business agreement that protects PHI (protected health information). PHI is information about health status, provision of health care, or payment for health care that is created or collected by a covered entity and can be linked to a specific individual. Applicant/member or AAA/Case Management with access to landline phone (one way) can be utilized in place of the software requirement. Landline/non internet use is appropriate (copper wires that carry their own power and work during blackouts). Follow up calls not involving billable service work requires I phone or Android encryption cell settings use or landline. Use of electronic health records, member portal access or app use are to be encrypted (end to end encryption) with business agreement as well.

a) Depending upon availability of SOURCE benefit funds, applicants who have been telephone screened and determined eligible for the Program may have to be placed on a waiting list for full assessment. When placed on a waiting list, an applicant will be advised of his right to be re-screened if his functional need or status changes. In the absence of applicant-initiated contact, applicants will be rescreened by the SOURCE EPCCM agency that conducted the first screening using telephone contact and re- administration of the DON-R every 120 days if held on the waiting list.

b) In the case of wait lists for SOURCE admission, the EPCCM Agency sends the completed DON-R with legible demographic information to the DCH Program Specialist via email or use of thee-mail address via secure method of transmission.

c) For those meeting SOURCE Medicaid eligibility criteria and wishing to pursue enrollment, information gathered from the screening will be used to determine admission priority and returned to the submitting EPCCM Agency to schedule assessment as program slots are available. In the case of a waiting list, those with the highest level of need as identified through use of the DON-R are admitted to the SOURCE Program.

d) Members who do not meet the eligibility requirements at the screening will be sent a Notice of Denial of Level of Care Elderly and Disabled Waiver Program Eligibility letter will be mailed to the applicant. The applicant has 30 days in which to request an appeal. (See Notice of Denial of Level of Care Elderly and Disabled Waiver Program Eligibility letter in the EDWP Forms Manual.)5382 and Section 1404

INITIAL ASSESSMENT

Any applicants or members of the E&D Waiver Program for whom English is not the applicant's/member's primary language must be provided interpreting services in their native language at all initial assessment for program admission, annual reassessment, and at any time when a change in condition will require a new evaluation of need. The interpreting services must be provided by an independent, conflict free agency, organization or contractor with no organizational affiliation to the case management or service provider agency. A documented record of the interpreter or interpretation agency, including all contact information (i.e. complete name, address, *CV (Curriculum Vitae), phone number and email), must be maintained by the agency or service provider agency that secured the interpretation service and will be made available to DCH upon its request as part of the applicant's/member's file. If the applicant's or waiver member's care is managed by a legal guardian, the interpretation requirements outlined hereinabove will also apply to the legal guardian.

The use of Medical Interpreters is necessary to ensure members are ESL (English as Second Language) are understood in their native language and conflict free case management standards are maintained.

All persons who meet screening requirements for SOURCE, and program slots are available

will be formally assessed in their homes (exceptions noted below) by EDWP RN/LPN prior to initiation of services, using the MDS-HC (v9) and other SOURCE approved Assessment Tools. The purposes of assessments are:

a) Evaluation of the member's medical and health status; functional ability; social, emotional and environmental factors related to illness, and support system, formal and informal, Level of Care determination, Care Plan development and delivery of community services.

b) Identification of urgent problems which require prompt attention.

c) Evaluate the member's home environment (assessing the physical structure and home safety, meeting caregivers or family members as indicated to assess informal support system, etc.). See Section 1005, Self-Care and Informal Support.

Exceptions to member "in home" assessment

a) Member is receiving in-patient care in an acute care facility awaiting discharge to a community environment

b) Member is currently residing in a nursing home

NOTE: For SOURCE Case Management agencies working in the electronic data system the following components of assessments will be done within the system and utilize electronic signatures if applicable:
MDS-HC v 9 LPN and RN sign MDS and the RN signature acts as the Appendix T when in the electronic data system.
EDWP Monthly/Quarterly Contact Sheet (both are incorporated into one form)
EDWP Quarterly Provider Contact Sheet
Modified Reassessment
Care Plans and Task Lists and Evaluations
Discharge Plan
Emergency Disaster Plan
Referral and Tracking
Advanced Assessments such as MMSE, SLUMS, PHQ9, Falls Risk
Evaluations for ADH, ALS, PSS, SNS, HDM, ERS
Service Order for providers
Medications will be put in the Medication TAB, do not add to MDS
Case notes in the Notes tab

Procedures for Initial Assessment:

a) The assessment process will be initiated within 5 business days of release from wait list. In situations where the standard of promptness is unmet, justification for failure to meet will be documented in the case notes of the

member file.

b) Nurses will assess all potential members using the MDS-HC (v9) assessment tool and determine eligibility for the Program based on ILOC criteria and need for community-based services.

c) When the MDS-HC is completed by an LPN, within ten (10) business days from the date of the assessment, the RN reviews the MDS-HC, completes and signs the MDS-HC Participant form to indicate supervisory review.

d) MDS-HC Participant Form confirms all who are present and assisted in interview for the MDS-HC and that the MDS-HC received RN review and agreement. It must be signed within 10 business days of the MDS HC assessment by the RN. It is part of the member assessment. It will also be uploaded to AHS with the assessment packet. RN signature in the electronic MDS will serve as proof of RN review of the forms if using Harmony.

e) Applicants who meet ILOC but have all needs met by informal supporters are not appropriate for admission to SOURCE.

f) Assessments will take place in the home of the potential member, unless enrollment is necessary prior to discharge from a hospital, nursing home or rehabilitation facility.

g) A caregiver, family member or advocate shall be present whenever possible during assessments for members with a legally appointed guardian, a known diagnosis of Alzheimer's or Dementia, or other known significant cognitive or psychiatric conditions

N o t e : Individuals who are wards under legal guardianship procedures may not enroll themselves in the SOURCE Program nor sign program-related documents

h) While an informal caregiver may assist with answering assessment questions as needed (see above in particular), the potential new member is the primary source of information whenever possible and is interviewed in person.

i) The Case Manager or nurse will review the program's operations with the potential member following the assessment, including selection of the site as Preferred SOURCE agency.

j) The following forms will be reviewed with the SOURCE member and signed.

- Updated SOURCE Rights and Responsibilities, obtaining signatures on two copies (one left with the member, one for filing

in the administrative chart) and including information on a member's right to appeal decisions of the site, signed at admission and at reassessment, at least annually.

- EDWP Authorization for Release Authorization and Informed Consent signed at admission, at reassessment, and at quarterly reviews.

- DCH Information about Elder Abuse, Neglect and/or Exploitation

Forms for review and signature may also include SFC Validation and Caregiver Attestation Form if needed, EDWP Info Sheet, Updated Case Management List, New EDWP Physician Evaluation, New Disease Management Physician Letter, Estate Recovery Information, Discharge Plan and Disaster Planning checklist at initial and reassessment, and EDWP Consent form.

k) The Case Manager will provide the member/caregiver with the names of all Primary Care Physicians in the area where member resides. Member may choose to use their current PCP if desired. All members enrolling must agree to use a Primary Care Physician.

l) The Case Manager must include directions to the member's home starting from the local SOURCE Enhanced Case Management office to member's home address.

m) Following completion of the admission assessment, the Case Manager will record all recommended services on the Care Plan Form.

n) Case Manager will request and record member feedback and signatures from both member and CM

Program Admission Procedures

SOURCE admission occurs with these steps following assessment:

1. Initial determination of eligibility using the definition in section 1884 as recommended by the assessment nurse using the information gathered from the MDS-HC (v9) and compared to the Level of Care Criteria
2. Submitting the assessment packet to Alliant Health Solutions (AHS), the Division of Medicaid's medical management vendor, for validation of level of care.
3. Prepare information on Community Supports available to member that may be used to support the member during their stay in SOURCE or information that can be used to support member at termination. Prepare for Discharge at the time of enrollment.
4. Receive confirmation of the level of care approval from AHS.
5. Review new/reassessed members by a multidisciplinary team.
6. Prepare Care Plan. Admission is considered complete upon the Medical

Director's order/signature on the Level of Care and Placement Instrument which provides the physician order for HCBS services, confirms LOC, and RN signature for certification of level of care. Care Plan completion is required within fourteen (14) days of this date

7. Upon completion of enrollment (synonymous with the PA approval/effective date) and initiation

    A. Provide the following completed documents to all service providers, See 606.4 of General Services Manual and EDWP CCSP Manual 1837:

        - MDS-HC and MDS-HC Participant Form with RN signature and date
        - Medication List
        - SOURCE Level of Care and Placement Instrument; must contain required signatures (physician and RN) and date of signatures
        - Level of Care Criteria Justification
        - Authorization for Release of Information and Informed Consent (Signature Page)
        - The EDWP Care Plan and task lists
        - SOURCE Service Order
        - Discharge Form
        - Emergency Disaster Plan
        - Nutritional Assessment for Home Delivered Meals
        - Any Advanced Assessments
        - Directions to the member's home, starting from the local SOURCE site to the member's home address Prior Authorization numbers (may put on transfer, Care plan, or App F

Rev. 07/22 Note: All services ordered must be listed on SOURCE Level of Care and Placement Instrument. The exception to this is if the member is not due for a reevaluation and the new service ordered does not require a reevaluation/ reassessment; in the case of new services ordered without full reassessment, the services are added on the Care Plan and indicated as ordered by physician or Medical Director on the Change in Service-No Reassessment letter.

    B. Provide the following completed documents to the member at the first face to face visit:

        - EDWP Program Participation Form 5389
        - Signed copy of the Service Order

NOTE: Assessment packets are submitted only through the secure AHS web portal for review. All correspondence related to admissions will be conducted through the secure web portal.

C. Documents to be submitted to Alliant Health Services via web portal include:

Level of Care and Placement Form (filled out in entirety)

Demographics

Level of Care Criteria justification for Intermediate Nursing Facility Care

MDS-HC form and the MDS-HC Participant Form with RN signature

Advanced assessments, if done

Medication Record Form

Case Notes

DON-R Screening Tool for initial assessments only

Process for Routine admissions:

For HCBS provider billing, SOURCE members are enrolled in the program after Prior Authorization LOC approval is given by AHS. The Prior Authorization effective date is the same date of the Initial assessment. SOURCE physician signature authorizes approval of the HCBS services including enhanced case management. The R.N. signs the ILOC form after concurrence is provided by AHS or DCH review.

Process for members who meet eligibility:

Eligibility requires AHS approval for any initial SOURCE clients or SOURCE member reassessments on or after 9/30/2013. Services may not be delivered until the AHS approval and a valid SOURCE Level of Care and Placement Instrument ordering HCBS services is in place.

Initial Admission Overview:

The Case Management Agency makes an appointment with the member for a fac- to-face interview.
A nurse completes the MDS HC.
When the MDS-HC is completed by an LPN, within ten (10) business days from the date of the assessment, the RN reviews the MDS-HC, completes and signs the MDS-HC Participant form to indicate RN review.
The MDS-HC Participant form is a signature page that confirms all who assisted in the interview for the MDS-HC that the MDS-HC received RN review and agreement. It must be signed by the RN within 10 business days of the MDS HC assessment. It is part of the member assessment.
Upon completion of enrollment and initiation of services, case manager will provide the following

completed documents to all community service providers, See 606.4 of General Services Manual:

MDS-HC and MDS-HC signature page with RN signature and date
Medication List
SOURCE Level of Care and Placement Instrument; must contain required signatures (physician and RN) and date of signatures
Level of Care Criteria Form
The EDWP Care Plan, Service Order, and provider specific Task Lists
Release of Information and Consent Form
SOURCE Service Order
Discharge Plan
Disaster Plan
Nutritional Assessment for Home Delivered Meals
Any Advanced Assessments
Directions to the member's home, starting from the local SOURCE site to the member's address

All sites shall maintain in the front of each chart for each active member a current Face sheet page with basic demographic information, to include the following:

Name
Date of Birth
Address/Phone
Male/Female
Medicare/Medicaid or SSN numbers

Note: For Case Management using the electronic data system, the following information will be found in other areas of the system other than the Face Sheet:

Directions to member's home - *Go to Edit Demographics and add in the box*
Responsible party information (phone, address) if applicable - *Add to Contact tab*
Emergency contact information (phone, address) - *Add to Contact tab*
SOURCE PCP - *Add to Contact tab*
SOURCE Case Manager - *Found in Provider Enrollment*
Date of SOURCE enrollment - *Found in Program Enrollment*
Diagnosis - *Found in MDS*
Advance Directives- Yes/No - *Upload to case Notes*
Discharge date - *Found in division, program and provider enrollment tabs when discharged.*

Case managers will provide the following completed documents to the member at the next face to face visit:

EDWP Program Participation Form 5389
Signed copy of the Service Order

The Case Manager submits documentation via the web portal to AHS. Exceptions, if the member has a current Prior Authorization that is not expiring within 3 months, it is not necessary to submit to
AHS. AHS reviews the assessment package and confirms Level of Care. Documents to be submitted via web portal include:

Level of Care and Placement Form (filled out in entirety)
Demographics
Level of Care Criteria form for Intermediate Nursing Facility Care
MDS-HC form and the with RN signature
Advanced assessments, if done
Medication Record Form
Case Notes (6 months of Case notes for reassessment)

While medical record submission is not required for all level of care reviews, any reviews that fall in the following categories may be supported by medical records:

- Assessments that reflect functional impairment not clearly associated with a medical diagnosis
- Assessments that reflect one or more behavioral health diagnoses with functional impairment not clearly associated with a medical diagnosis
- Assessments that reflect diagnoses not typically expected to result in long term functional impairment such as hip fracture or knee replacement

Alliant Health Solutions and/or DCH staff may request and/or retrieve medical records to support any level of care determination. The request is for the purpose of determining eligibility. Information may include hospitalization information, medical equipment needs, previous treatment, and medical history.

Following level of care approval by AHS, the member assessment and care plan recommendations are to be reviewed by the multidisciplinary team.

Case Managers will use the following format in presenting newly eligible members to the weekly admissions meeting of the multidisciplinary team:

(1.) Member name, age and diagnoses
(2.) Caregiver information, if applicable
(3.) ADL/IADL impairments from MDS-HC Assessment
(4.) Current medications
(5.) SOURCE physician selected from panel
(6.) Factors complicating care planning (lack of support, recent hospitalization,

etc.)

(7.) Recommended SOURCE services
(8.) Other community services planned or in place
(9.) ADH level recommended (See ADH manual)

The team reviews information to ensure that:

(1.) Informal support is analyzed and maximized
(2.) Services recommended are logical and cost effective
(3.) Key health status issues are identified, with urgent problems addressed

Following discussion of information presented, the multidisciplinary team reviews the Level of Care, MDS HC and other SOURCE approved assessment tools for development of the care plan and service plan.

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The Medical Director and/or member's primary care physician confirms that the member meets eligibility requirements for the SOURCE Program and orders specific services on the SOURCE Level of Care and Placement Instrument by signature.

Once the physician signature is on the level of care form, then a Service Prior Authorization can be created in the Medicaid information System.

If applicable, the team also assigns the ADH level of service.

AHS communicates the level of care approvals to DCH for admission upon request.

Ineligible members

Ineligible Initial Clients (New Clients)

Process for new clients who do not meet admission criteria due to incomplete information uploaded (technical denial)

- AHS does not validate/does not confirm Level of Care and eligibility
- Sends a contact us to Case Management provider regarding documents left out of upload
- Denial for an incomplete application will only be communicated if the SOURCE agency fails to submit the require documents to AHS for review with-in 30 days.
- Required documents that should be uploaded listed above.

Process for new clients who do not meet LOC

- The SOURCE agency notifies the member and makes sure any questions are answered
- The agency Medical Director and R.N. DO NOT sign the SOURCE Level of Care
- SOURCE Agency reviews the discharge plan with community supports, adding information as needed, giving it to member when complete (See Discharge Planning sheet) Provide the discharge plan to the appropriate parties, upon request, at a hearing

conducted by an Administrative Law Judge (ALJ) from the Office of State Administrative Hearings (OSAH) on an adverse action decision made by the Case Management, Alliant, or utilization review (UR). For a member denied at initial assessment, provide contact information on the AAA/ADRC based on the region where the member resides for non-waiver services they may be available to them. https://aging.georgia.gov/locations

Process for established members who do not meet continued eligibility at reassessment

- If a member does meets Level of Care (and does not appeal) or is discharged for any other reason, the site will notify all service providers and end all lines on the service Prior Authorization.
- Except in cases where member meets immediate discharge criteria (i.e. threatening behavior),
- the agency should attempt to determine if the member is going to appeal and give the member 30 days before ending the service Prior Authorization.
- Service Prior Authorizations should be ended in 30 days by the Case Management agency if member has not appealed.
- The appropriate forms should be placed in the member's chart.

Routine Reassessments (Complete Reassessment Packets)

Source members are evaluated for continued eligibility at least annually, and more often as necessary as directed by AHS, or as directed by DCH. Re-evaluations are to be completed by a licensed nurse (currently licensed in the state of Georgia). Re-evaluations completed by an LPN must be reviewed and approved by a supervising RN. Reevaluations are sent to AHS to obtain approval. The SOURCE case management agency confirms that the member continues to meet criteria for:
Eligibility using the definition in section 1884 including Intermediate Level of Care for nursing home placement
Continued eligibility, appropriateness, and need for SOURCE services
Allows for adjustment of the Care Plan goals and service plan. Note: All services ordered for member at the time of reevaluation must be listed on SOURCE Level of Care and Placement Instrument, Line 23

Schedule face to face with member starting 90 days prior to the expiration date of the current LOC and review with member/member representative all documents to be reviewed and signed, to include the Rights and Responsibilities, Authorization Release Authorization and Informed Consent, update Discharge Plan and Emergency Disaster forms, New Disease Management Physicians Letter.

1. Complete MDS-HC (v9) Assessment
2. Complete SOURCE Level of Care Placement Instrument
3. Discuss with member continued eligibility or if indicated possible ineligibility
4. Initiate the development of a new Care Plan with the member/representative

5. Obtain AHS approval on all annual reassessments with MDS

6. Present member information and documentation at multi-disciplinary team meeting

7. Complete certification of LOC and continued participation in SOURCE

   a. Provide copies of reassessment documents to community service providers before end date. The following documents are maintained as part of the SOURCE member clinical record, See 606.4 of the General Services Manual.
      - The MDS-HC and MDS-HC signature page, with RN signature and date
      - SOURCE Level of Care and Placement Instrument, with required signature (s) and date (s)
      - Level of Care Criteria Form
      - Release of Information and Consent Form
      - The SOURCE Care Plan and Task Lists
      - SOURCE Service Order
      - Disaster Form
      - Discharge Form
      - Any Advanced Assessments
      - Directions to the member's home, starting from the local SOURCE site to the member's home address.

8. If member is not approved for SOURCE during the Reevaluation/Reassessment process, and the member appeals, a copy of the AHS notice of appeal or the member's copy of DCH Legal Services Division acceptance of member's appeal, will extend the LOC currently in place.

While medical record submission is not required for all level of care reviews, any reviews that fall in the following categories may be supported by medical records:

- Assessments that reflect functional impairment not clearly associated with a medical diagnosis
- Assessments that reflect one or more behavioral health diagnoses with functional impairment not clearly associated with a medical diagnosis
- Assessments that reflect diagnoses not typically expected to result in long term functional impairment such as hip fracture or knee replacement

Alliant Health Solutions and/or DCH staff may request and/or retrieve medical records to support any level of care determination. The request is for the purpose of determining eligibility. Information may include hospitalization information, medical equipment needs, previous treatment, and medical history.

NOTE: If members no longer meet eligibility criteria for SOURCE participation refer to Section 1890 of this manual.

Modified Reevaluation/ Readmission into SOURCE (see also 1842)

Modified Reevaluation Process may be used for members with Current PA greater than 3 months from expiration. Such as:

Client is discharged from a nursing home stay

- Client is discharged from an acute care hospital after a 60 day stay
- Significant change in client condition/situation
    - Significant change in mobility (from walking to unable to walk or w/c to bedbound)
    - Significant change in cognition (orientation, ability to make own decisions, make needs known)
    - Significant change in point of service (ALS to private home or vice versa)
    - Significant change in ability to participate in care needs (focus on decline in late loss ADLs from last MDS assessment)
- Adding a skilled service
- Terminating a skilled service
- Adding non-skilled service
- Received as a transfer from another agency or internal transfer
- Client is moving from PSS to determine a recent decline of the member that does not receive a daily 5 hour assessed need if requesting Structured Family Caregiving. A physician order will be added using the Change in Service Physician Letter signed by the PCP or Medical Director. CC completes the Appendix D to determine the 5 hours of care every day prior to ordering Structured Family Caregiving.

This policy is for Medicaid members who have an active Level of Care PA with Alliant. Interview of member for this process may be conducted by LPN or RN.

Procedure:

The LPN/RN completes the Modified Reassessment form with the Member/Representative.

Review and update Care Plan, Task Lists, and Service Order to include any changes noted in care needs.

If this is due to a transfer, be sure the Transfer Form is complete from the agency that transferred to receiving agency and it has been sent to AHS for LOC PA transfer.

RN reviews and signs modified reassessment form for members with active prior authorization/approval. RN supervisory review indicates that medications and treatments are consistent with diagnosis and appropriate to be given at home. All urgent Information is directly communicated to Case Management staff and documented.

COMMUNITY SERVICE PROVIDERS

Each Community Service Provider should receive this information following:

Source Modified Reassessment Sheet

Source Updated Care Plan, Service Order, and Task Lists
Authorization of Information and Informed Consent Form
Medication List if changes
If this is a new transfer in, include the MDS-HC and SOURCE Level of Care and Placement Instrument sent by the sending agency.

SOURCE Member
(Internal and External):

SOURCE members may transfer to another SOURCE site within the same company (Internal transfer) or to another SOURCE agency, CCSP agency, or ICWP agency (External transfer) and remain eligible for the Elderly and Disabled Waiver.

Upon notification of a transfer to your agency or leaving your agency, contact the member or member representative to verify informed choice of the transfer and date of transfer. Contact must be made with the receiving agency lead to determine that they will accept the member being transferred.

Discharging/Transferring Agency:

1. With a current LOC PA, Complete the Universal Waiver Transfer Form, to include the last date of service, and upload to Contact Us on MMIS LOC PA to request the transfer of LOC PA.
2. Notify the AAA for the CCSP agency with demographic information to create a chart in Harmony if applicable.
3. Send to receiving agency three months of documentation to include the most current MDS, Case Notes, Medication List, and SOURCE Level of Care and Placement Instrument. DO NOT obtain the Medical Director's signature on the SOURCE Level of Care and Placement Instrument to discharge waivered services when a member is transferred with a current LOC PA. Current SOURCE Level of Care and Placement Instrument is used to broker services with the receiving agency and is good until the LOC expires.
4. Notify HCBS providers of the last day of service for the discharging/transferring agency.
5. Ensure all lines on the service PA have ended.
6. The Transfer Form – Supplement Checklist must be completed in full to include providers name on the form and submit both transfer forms to the DCH Waiver Unit.

Receiving Agency:

1. LPN/RN will complete a home visit contact and complete the Modified Evaluation, discuss services, and review and revise the Care Plan if needed.

2. If the LOC is expiring within the next 60 days, the nurse will do the entire MDS and packet and submit to AHS for approval. Contact DCH to request it be

expedited through AHS.

Transfers from SOURCE to CCSP no longer require care to begin on day one of the next month. Transfers can now occur on days other than the end of the month. The discharge date from one to the other must be agreed upon in advance so the worker can end date the services PA before the new services can begin. The two service PAs cannot overlap. The area the member is leaving (Discharging/Transferring Agency) will bill for the month the transfer occurs. The Receiving Agency will bill the following month and ongoing after the transfer took place.

Note: Transfers to ICWP are recommended on the first date of the month with communication between case management agencies occurring in the month prior to the transfer.

With the loss of the SSI category or any payment category of Medicaid payable for Source, the current case management has 3 days to notify the member, verify the reason for the loss of applicable category, and refer to case management in CCSP (can be same agency as Source if approved for CCSP and that county of residence) if unable to restore. DCH has the 449 clients automatically changed to CCSP Medicaid so the receiving CC site will upload the signed LOC and CCC to DFCS ASAP. The Source site will alert the applicable AAA in those 3 days and collaborate member choice of new agency. In the event the member refuses to transfer to CCSP, the Source Case Management will complete the termination from EDWP, with the issue of the 5382, and close the file out by the end of the current month if no appeal request.

IF	THEN
If client has been without services for greater than 60 days and has an active LOC PA of greater than 90 days prior to expiration	Have the nurse do a modified reassessment and update the care plan and send to the providers
If client has been without services for greater than 60 days and has an active LOC PA that is within the 90 days of the expiration	Have the nurse do a reassessment and upload to Alliant as a reassessment and new care plan and send to providers.
If client has been without services for greater than 60 days and the LOC expired during that time, if within 60 days of expiration	Have the nurse do a reassessment and upload to Alliant as a reassessment and dates will be adjusted to meet old LOC. Do a new care plan and send to providers.
If client has been without services for greater than 60 days and the LOC expired during that time and the expiration is greater than 60 days	Have nurse do an Initial assessment and upload to Alliant for a new LOC PA. Do a new care plan and send all new paperwork to providers.

1886 Care Plan

SOURCE utilizes Care Plans to develop an individualized plan of care to identify goals to achieve expected outcomes. Care Plan, designed around indicators associated with chronic illness and impairment, are individualized plans written and implemented for each member. Care plans, while not disease-specific, address risk factors held in common by people at the SOURCE Nursing Home Level of Care. The SOURCE Assessment nurse, with input from the case manager, is responsible for development of the member care plan at initial assessment and at each re-evaluation.

Members and informal caregivers, Primary Care Provider staff, RN's/LPN's and Case Managers, together implement the Care Plan, adjusting the plan when necessary to meet goals.

The program uses Care plans to:

a) Individualized case management practices
b) Identify roles for specific participants
c) Identify gaps in self-care/informal support, creating a framework for paid SOURCE services

d) Target and analyze problem areas for individual members and across the entire program

SOURCE promotes member independence, self-care and assistance from informal care givers. When appropriate, the case manager may coordinate education or training for members or informal care givers to teach direct care, patient education, and monitoring of chronic conditions. Self-Care and informal support are reflected in the development and implementation of each care plan. At minimum, the member Care plan will address the following:

- Nutrition/weight
- Skin care
- Key clinical indicators (blood pressure, blood sugar, weight monitoring and lab studies)
- Medication compliance
- Keeping appointments with primary care physicians
- Performance of ADLs and IADLs
- Transfers and mobility
- Problem behavior (s), if applicable
- Informal care giver support
- Discharge Planning
- Emergency Disaster Plan

Care Plan Development and Completion

Care Plan development requires that the CM/LPN/RN use information gathered from many sources to produce and maintain a consensus between members/caregivers and Primary Care Providers to meet individual goals. The Source assessment nurse and case manager will evaluate the member's need for assistance with performance of his/her activities of daily living and instrumental activities of daily living, monitoring of chronic medical conditions and other areas which impact the member's ability to continue living in the community. Evaluation begins with the referral and screening process through the initial assessment and continues for the duration of the member's length of stay in the program. Assessment nurses and case managers will:

- Determine member formal and informal support, availability and reliability (Whenever possible, nurses/CM's will meet with informal caregivers to discuss care planning)
- Add to SOURCE Care Plan profiles when information is obtained from the member/family during the assessment
- Effective date and expiration date of the Care Plan will be taken from the Prior Authorization dates given by AHS.
- A new effective date that services were restarted may be documented by a Case Management agency on the care plan if service is interrupted during an active Prior Authorization.
- Short term hospitalizations (less than 2 weeks), or temporary moves will require a case note. Transfers and if the member has needs for different services will require

the Change In Service Physician form signed by the PCP or Medical Director to be documented with a Care Plan, SOURCE Service Order, task lists and evaluations must be updated and case note written.

- A prolonged Span for hospitalization, nursing home stay, rehab stay, may meet requirements for a modified reevaluation and care plan, service order and task lists will be reviewed and changed if needed.
- Prior Authorization expiration dates are only given by AHS.
- Complete the Care Plan within fourteen (14) days of the completion of the enrollment process which includes determination of level of care, physician signature, and is finalized by the RN signature. Present the Care Plan at the Inter-Disciplinary Team. Medical Directors signature on the Level of Care form will confirm care plan approval.
- Case management or Physician may add or delete services (with explanation) for the member on the care plan. The Change In Services Physician letter signed by the Medical Director will confirm the changes.

NOTE: When a new service is required as the result of a change in member support or functional capacity; the Medical Director signature and date on the Change In Service Physician Letter will confirm his or her review and approval of the new plan of care.

Completed Care Plan

Completed SOURCE Care plan will have understanding and agreement from the member/care giver and the Medical Director. The Case Manager will formally review the care plan goals every monthly and quarterly client contact.

Initial review of the care plan and task lists with the member confirms that:

- member understands expected outcomes
- plan accurately describes self-care capacity and informal resources
- reimbursed services are offered at the appropriate level
- Information on community services that will enhance member's wellbeing are provided.

Case managers will review care plan goals and task lists, evaluations during regularly scheduled quarterly contacts with the member to ensure that the plan is current and continues to support the member's ability to remain in the community. The provider task evaluation forms will be used to document any issues noted.

During the initial review of the individualized member care plan and task lists with the Medical Director, the following exchange of information will occur:

- PCP role in patient education and treatment from obtained medical records
- monitoring of chronic conditions at home
- self-care capacity/informal supports identified
- reimbursed services ordered

CM documents in case notes medical director's recommendations. Bi-annual PCP notification using the EDWP DM Physician Letter will include review of variances of the care plan goals.

Service provider review of Care plan allows provider agencies to:

- confirm the authorized services ordered
- understand and acknowledge service provider role in supporting member care plan goals
- understand the member and caregiver role (s) in meeting care plan goals

Care plans are discussed with provider on new enrollment/reassessments and with changes during provider meetings to ensure provider awareness of their role. EDWP Notification Form, referral, or other documented communication will be amended by the case notes as indicated to reflect changes in the care plan

1887 Reimbursed Services

To implement the Care Plan, the Case Manager will refer the new member for reimbursed services, if applicable. Information provided to the agency must be sufficient to allow for effective service delivery and accurate billing.

Procedures:

A. The member will choose their providers from active provider list.

B. Due to the complexity of care involved, Case Managers will discuss new referrals by phone or in person, for the following service categories:

(1) Personal support/extended personal support
(2) Adult Day Health
(3) Alternative Living Services
(4) Home Delivered Services
(5) Structured Family Caregivers
(6) Consumer Directed Personal Support

C. Home delivered meals and emergency response system referrals will not require a phone call prior to making the referral in writing.

D. The Case Manager will complete the SOURCE Service Order.

E. In addition to demographic information, the SOURCE Service Order must include specific units of service requested and the Authorization Number.

F. Additional information pertinent to service delivery for an individual member will be noted on the Service Order.

G. All providers will also receive copies of the following which are maintained as part of the SOURCE member clinical record:

- The MDS-HC and RN Review and Signature page.
- Medication List
- SOURCE Level of Care and Placement Instrument
- Level of Care Criteria
- The SOURCE Care Plan and task lists
- Rights and Responsibilities
- Discharge Summary

- Emergency Disaster form
- Demographics sheet

H. Providers will send the Case Manager an EDWP Notification Form confirming the service level and the date services will begin.

I. If the EDWP Notification Form does not match the Service Order, the Case Manager will call the provider to clarify the referral.

J. Changes in paid assistance will be documented in the Case Manager's notes and on the Care plan, See also Section 1405, Right to Appeal (regarding decreasing or terminating services)

(1) The Case Manager will review the recommended service change(s) with his/her supervisor.
(2) If the Supervisor approves the change, the Case Manager will authorize the new service level in writing, by completing the EDWP Notification Form and sending a copy of updated care plan and task lists to applicable service providers.
(3) The original EDWP Notification Form is filed in the member's chart.
(4) The Case Manager will amend the Care plan and task lists as indicated, forwarding an updated copy to the member/caregiver.

NOTE: EDWP Notification Forms are acknowledged, in writing by the receiving agency and returned to the initiating agency within three (3) business days.

K. Changes in paid assistance will be documented in the Case Manager's notes and on the Care Plan, by drawing a single line through the earlier Care Plan entry and initialing and dating the current entry. See also Section 1405, Right to Appeal (regarding decreasing or terminating services)

1888. **Care plan Variances**

A Care Plan Variance describes a goal not met by a member at any point during a quarterly review period. For any goal not met, corrective action by the Case Manager is required. The Case Manager will act quickly to help members resolve variances, to prevent further complications that may jeopardize health or functional status.

Procedures

a) Case Manager will identify the variance, recognizing problematic issues as goals not met and uncovering the source(s) of the problem.

b) Case Manager will act to resolve the variance. Specific steps taken will depend on the member's individual circumstances, and on which goal was not met and why. Examples of corrective action may include:

- Arranging patient education for the member or informal caregiver

- Scheduling an appointment with Primary Care Provider
- Increasing service levels or changing service categories
- Coordinating with provider on service delivery issues

c) The Case Manager will document all variances appropriately:

(1) If the variance was discovered or noted before the quarterly home visit, the Case Manager will indicate the issue on the Monthly Contact Sheet, the care plan, task lists, evaluation lists, and case notes as applicable.

(2) If the variance was discovered or noted at the quarterly review home visit, indicate the variance on the Contact Sheet Quarterly Review section, the care plan, task lists, evaluation lists and in the case notes.

(3) The Case Manager will further document corrective actions in the member's case on EDWP Notification Form to providers approving service level changes, on the Care Plan if a change to the plan was made, etc., as applicable.

(4) The Case Manager will document variances with the PCP on the bi-annual EDWP DM Physician Letter and service providers using the EDWP SOURCE Case Conference and Complaint Resolution as applicable

1889 Concurrent Review

Communication is key to the SOURCE concept of integration. Defined formally in the program as concurrent review, there are four fundamental principles to SOURCE communication:

- Preventive efforts will be effective and current
- Problems will be quickly identified
- Action will be promptly taken by the appropriate parties to resolve problems
- Resources will be appropriately targeted for maximum results and cost efficiency

Case Managers and Care plans are at the core of concurrent review in SOURCE. To reach the program's stated goals, Case Managers initiate and facilitate communication with SOURCE members/caregivers, Primary Care Providers, program supervisors, and if applicable, providers; Care Plans provide guidance and formal structure for the concurrent review process.

All key players in SOURCE may possess information on the member's current condition and on Care Plan variances; however, with increased contact, familiarity or specific skills, each contributes unique perspectives as well:

Members/CG:	current condition (self-report); preferences; capabilities dynamics/ informal support
Primary Care	clinical condition, recommended treatments and compliance**;** information from diagnostic procedures, specialist visits, etc.
Providers:	current condition as observed by trained staff; household dynamics/informal support as observed externally

In addition to the program's key players, concurrent review includes other entities as appropriate, on an individual basis (example: dialysis center patients) or for a limited time (example: hospitalizations).

The job of the Case Manager and his or her supervisor is to analyze and use all information received to help the SOURCE member stay as healthy as possible and to meet Care Plan goals.

Communication with key players falls into two categories: scheduled or PRN (as needed in response to recognized triggers). Scheduled contacts serve as an overview for key players, an opportunity to spot patterns or trends and respond preventively. PRN contacts more typically address individual issues as they arise.

Scheduled Contacts with Members

The Case Manager will regularly initiate contact with the members/caregivers and will make follow up contacts as needed with providers, Primary Care Providers, etc., on a member's behalf.

The Case Manager will also respond to calls initiated by SOURCE members/caregivers or on behalf of members, again taking follow-up steps as necessary. While minimum standards for contact are described below, the Case Manager will communicate with or on behalf of members as often as necessary to meet Care Plan goals and to stabilize or improve health status.

Direct contact between members/caregiver and providers also occurs frequently in the model; the Case Manager encourages engagement of the members/caregivers to the fullest extent possible in working toward optimal health and functional status.

Scheduled contacts with members/caregiver will occur according to the following timetable, at a minimum. The Quarterly Contact Sheet and the Care Plan, task lists, and evaluations will be used to record scheduled member contacts, appended by member case notes as necessary.

Monthly case notes must reflect what type of contact the Case Manager had with the member and a summary of what was discussed. Quarterly case notes must reflect review of member's Care Plan, which will include goals not met, and a plan of improvement/correction. Case notes must reflect follow up to assure the plan is working, and resolution of identified problems.

Procedures for Scheduled Contacts:

a) **SOURCE Service Confirmation:** The Case Manager will confirm initiation of services during monthly contact following referral. The CM will take any follow-up steps required if services have not begun. Service referrals and confirmation will be indicated in case notes, on a EDWP Notification Form (ENF) or on a SOURCE Referral Form.

b) **Monthly Contacts:** The Case Manager will contact all members a minimum of once each month, to be documented on the Contact Sheet and in case notes if necessary.

(1) The Case Manager will indicate the method of contact (phone, home visit, other).
(2) The Case Manager will review goals of the Care Plan with the member/caregiver and will ask the member/caregiver to report any additional health or functional status issues, including initial PCP visit as applicable.
(3) For Care Plan outcomes with multiple goals, the Case Manager will indicate which goal was not met.
(4) The Case Manager will take appropriate follow-up actions as indicated.
(5) The Case Manager will sign and date the Contact Sheet for each monthly contact.
(6) Monthly contacts will be documented by the Case Manager on the contact sheet, appended by case note entries if required for complete documentation of service quality, progress toward goals and any other issues impacting care.

c) **Quarterly Reviews:** The Case Manager will formally review Care Plan goals every quarter.

(1) At the member's home, the Case Manager will review goals of the Care Plan with the member/caregiver.

(2) The Case Manager will review the existing Care Plan, and Task Lists, making updates as indicated due to changes in health/functional status of the member, informal support changes, etc.

(3) For a goal not met, the Case Manager will discuss with the member/caregiver options on how best to resolve variance.

(4) The Case Manager will ask the member/caregiver to report any other issues potentially jeopardizing health or functional status.

(5) The Case Manager will observe the member's household for cleanliness and safety.

(6) Quarterly contacts will be documented by the Case Manager on the contact sheet, appended by case notes if necessary.

(7) The Case Manager will take any additional follow-up actions indicated by the quarterly review.

(8) Changes to the Care Plan will be documented dated and signed by the Case Manager on the Care Plan.

(9) Copies of the new Care Plan, Service Order, Evaluations and Authorization of Information and Informed Consent form will be provided to the service providers.

d) **Re-evaluations:** A formal re-evaluation will be completed for all members annually. These will be submitted to AHS following instructions in section 904:

(1) RN/LPN will complete the MDS-HC (V9) level of care assessment and medication list. A new Records Release Authorization and Member Rights and Responsibilities must be signed and dated.

(2) The Case Manager will review the existing Care Plan, services and any issues jeopardizing the health or functional status of the member at the re- evaluation, following the procedures for quarterly reviews.

(3) A new Care Plan will be developed and reviewed for each member, following procedures from
(4) The level of care will be reviewed at weekly teams meeting and Medical Directors signature on the new Level of Care form will justify the new service order, care plan, and task lists.
(5) AHS or DCH will validate Level of Care with the complete assessment package submitted by the Case Management Agency as of 9/30/2013.
(6) Recommended changes in the Level of Care will be reviewed by the site's multidisciplinary team as determined by the MDS-HC assessment as conducted by the RN/LPN.
(7) The R.N. and Medical director signature on the Level of Care and Placement form should follow (as of 9.30.2013 after AHS validation) with multidisciplinary team review and confirmation

Note: a SOURCE Level of Care and Placement Instrument must be completed, at least annually, to verify continued Level of Care eligibility unless a legal notice is given to extend the expiration date

It is strongly recommended that at the Case Management third quarter face to face visit, the Member is assisted to make a functional assessment appoint with their PCP. The functional assessment document should be given with explanation to the PCP for this visit and upon completion, submitted to AHS. See EDWP Physician Evaluation form.

Scheduled Contacts with Primary Care Provider

Primary Care Providers will be kept abreast of the member's care and concerns via the ECM DM Physician Letter that is submitted initially and bi-annually to the physician. The letter's intent is to provide information on the status of the member, inform of applicable problems quickly and share information on resources (informal and paid) effectively. Changes/updates are discussed and any PCP recommendations from return of this letter are to be documented in the case notes. Special attention should be given to any problems, variances, and all Incident Reports that the member may have had since the last letter for to PCP in the disease management process.

PROCEDURES
For all SOURCE members communication between the Case Manager and the primary care provider will take place following the approval of the Initial assessment and at least bi-annually thereafter using the EDWP Physician Letter.

Observations in health or functional status
Incident Reports if not already reported to physician
Care Plan variances
Observations noted in the home.
Request for Equipment/supply needs
Medication List
Clinical Problems to include Hospitalizations
For new members: Attach Care Plan

This form is not intended for return by the Physician but may do so if needed and updated information must be put in the case notes and changes made to Care Plan if needed.

Contacts with Service Providers

In addition to the four principle themes of concurrent review described earlier, contacts ensure that the SOURCE Enhanced Case Management and providers share the same understanding of services levels and responsibilities.

Procedures for Scheduled/PRN Contacts with Direct Service Providers

Member initial referrals, discrepancies, discharges:
SOURCE Case Managers will document exchange of information with Direct Service Providers bi-annually and PRN utilizing the EDWP Provider Case Conference and Complaint Resolution form when reviewing service delivery/provider performance issues, dissatisfaction, and other areas requiring resolution. Follow up should occur after reports are received by phone, face to face, or written communication.

- Details of complaints/concerns requiring resolution will include:
    - Re-brokering of Provider – before re-brokering ALS, ADH, PSS/EPS, or SFC services.
    - Service Order Issues – member complaints
    - Provider/Case Management Complaint – failure to provide timely documentation
    - Client/Caregiver/Family Complaint – behaviors, requests to change Case Manager/aid assignment, other
    - When applicable, DCH Incident Reports (initial and follow up) may include the EDWP Provider Case Conference and Complaint Resolution form.
    - Case Management will document action needed, responsible party, and final complaint resolution in case notes.

- SOURCE Case Managers and Direct Service Providers will utilize the EDWP Notification Form to communicate. EDWP Notification Form will be received from providers prior to adjustments on the Service PA.

- A complaint log will be maintained by Case Management on those providers with frequent complaints such as the member not receiving timely services or poor services in the home.

- Bi-annual conferences will take place with providers serving a site's members, unless otherwise specified on the SOURCE Case Management Complaint Log, for these services:

    - Adult Day Health
    - Personal Support/Extended Personal Support
    - Alternative Living Services

NOTE: With the agreement of both the SOURCE Site (EPCCM) and the provider, conferences may take place by phone, or by a mutually agreed upon electronic method. Provider conferences will include for Enhanced Case Management members served by the agency, efforts to resolve:

- Member Care Plan variances and Incident Reports
- Potential nursing home placement
- Member service issues and service delivery complications

Following completion of the annual re-evaluation for each SOURCE member, the case manager will send to each provider the updated Care Plan. Changes in service units or schedules or significant changes in responsible parties will be accompanied by an EDWP Notification Form to provider affected.

For discharges initiated by the SOURCE Enhanced Case Management, the provider will confirm notice of a service discharge by sending a completed EDWP Notification Form to the Case Manager.

For discharge of a member initiated by the provider, the provider will notify the site of a discharge using the EDWP Notification Form. Discharge by a provider should ONLY occur after a case conference is held with the case manager, member, and service provider. A thirty-day (30) discharge letter must be issued.

Contacts with Case Management Supervisor

Contacts with the Case Manager Supervisor assists the Case Manager in negotiating complex situations among multiple parties. Case Management supervision will occur on an as needed basis.

PRN Contacts

Problems complicating the lives of people with chronic illness may not coincide with scheduled monthly or quarterly Case Manager contacts. The SOURCE model places responsibility on Case Managers to ensure that communication with or between the right players happens at the right time to meet program and Care Plan goals.

Communications with members (and subsequent follow-up actions) that fall between scheduled contacts are made in response to member need. While most such contacts fall into areas related to clinical/functional status or service delivery, members may also contact Case Managers about eligibility, housing, items not covered by third party payers, etc. – in short, any issue potentially jeopardizing their ability to continue living in the community.

Providers (particularly PSS/EPS, ADH and ALS) frequently develop a close relationship with members/CG for several reasons:

- The frequency with which they encounter members/CGs
- The intensely personal nature of community services
- The social isolation of some members

Communication with the Case Manager Supervisor around identified triggers is also critical, allowing the Case Manager to share the substantial responsibility of making decisions and taking actions that best support members in community living.

Procedures:

1. All key players in the program will be encouraged to report to Case Manager's any issues that threaten a member's health status or ability to live in the community.

2. All key players will be educated on using the SOURCE 24-hour phone number for case management and primary care assistance offered from the site.

3. All key players will identify a key contact person to facilitate and communication for SOURCE members (may be the actual member, as indicated).

4. The individual SOURCE CM assigned to a member is the contact person identified for key players.

5. Triggers for PRN communication between players are:
    - Care Plan variances
    - Potential nursing home placement
    - Hospital encounters—inpatient or emergency department
    - Acute illness/exacerbation of chronic condition
    - Significant change in function—physical or cognitive
    - Suspected abuse or neglect
    - Service delivery complications
    - Housing/other residential issues
    - Family dynamics/informal support changes

- Transportation needs
- Member's desire to appeal a Case Manager decision Other factors jeopardizing health/functional status or community residence

Additional PRN communication with PCPs includes:

- New patients with SOURCE (review Care Plan; file copy on chart) Episodic/acute illness or exacerbation of chronic illness
- Medical triage/advice
- Referral to/communication with specialists (or ancillary services, diagnostic, etc.)
- Scheduling appointments
- Urgent equipment/supply needs
- Pharmacy/prescription needs.

6. If a specific CM is unavailable, the key player can relate information to the CM on call or to a CM supervisor.

7. Triggered information will flow from the CM to key players as indicated to resolve problems and achieve Care Plan goals.

8. Case Manager's will document PRN contacts and follow-up actions in a member's case notes, on Contact Sheets or on Care Plans as indicated.

9. Case Manager's will take any follow-up actions indicated to resolve outstanding issues, facilitate services or prevent further complications. Examples of follow-up actions includes:

- Changing Services, increases or decreases
- Evaluating functional changes by a home/hospital visit
- Scheduling a medical appointment
- Arranging a family conference to resolve care giving responsibilities
- Making transportation arrangements
- Referral for DME
- Assisting member in obtaining non-covered supplies
- Changes in Level of Care as determined by MDS-HC

Disease State Management

In lieu of disease management provision by the Enhanced Case Management agency, case managers are able to use the EDWP Disease Management Physician Letter to provide information regarding the SOURCE member to the primary care physician or primary specialist medical provider. Note: If sending communication to a specialist provider, case managers will

copy the primary care physician on the correspondence. The intent of the EDWP Disease Management Physician Letter is to provide information regarding the following:

- SOURCE services and potential impact on medical or health status
- Any change in condition or reported new symptoms
- A full list of all medications observed in the home with the frequency, dosage and prescribing physician. This would include any observations or concerns including member's failure to take the medication as prescribed.

The physician may or may not return the EDWP Disease Management Physician Letter but a copy of the tool must be retained in the chart along with the date and the method used to notify the physician, e.g. facsimile with confirmation, secure e-mail with confirmation of receipt, or U.S. Postal mail. All subsequent communication with the physician or other medical provider must be documented in the member record.

1890 Provider Performance Monitoring

To function effectively and assist members in meeting program goals, all key players in SOURCE must provide accessible, effective and reliable service. Enhanced Primary Care Case Management providers will comply with all monitoring and reporting activities as required by the Department of Community Health/Division of Medical Assistance.

Conflict Free Case Management is required by the federal government. DCH restricts agents that conducts the functional assessment and/or case management to also provide services to that individual.

Procedures:

***SOURCE CASE MANAGEMENT* SITES**

DCH LONG TERM CARE UNIT MAY REQUIRE A CORRECTIVE ACTION PLAN (CAP) FOR NON-COMPLIANCE IN THE FOLLOWING AREAS. PLEASE SEE THE REFERENCED SECTIONS FOR COMPLIANCE REQUIREMENTS:

- Source Programmatic Report (Monthly)
- SOURCE Case Management Team Meetings Documentation (See section 1884)
- Program admission procedures: submitting all documentation to AHS (See section 1885)
- Program admission procedures: documents submitted to providers (See section 1885)
- Member Forms in Chart; forms present and documentation complete (See section 1889)
- Bi-annual Contacts with Primary Care Providers (See section 1305)
- Maintaining 24-hour call system: documentation and maintaining system (See section 1890)
- Hospital tracking through Incident Reporting and intervention Logs

(See section 1890)

- Utilization Management oversight documentation (See section 1890)
- Standards of Promptness-Including submissions to AHS are prior to level of care expirations (timely)
- Discharge planning documents: Complete and Comprehensive discharge planning documentation.
- Guardian notification occurs as outlined (See 902 Procedures (d) and 1890 Right to Appeal)

DCH may require a Corrective Action Plan (CAP) for non-compliance. Sites must submit a CAP within 14 calendar days of notice of non-compliance and Corrective Action Plan. If an approved CAP is not properly applied or executed, DCH may impose additional sanctions ranging from new member suspensions up to suspension of participation as a Case Management Agency. The areas listed above are frequently requested areas, SOURCE Case Management Companies are still required to follow all SOURCE policy.

Utilization Management

As stewards of significant state funding via the authorization of HCBS services, SOURCE Case Management Provider must ensure that the value of Medicaid's long- term care dollars is maximized. Sites will develop an internal system of monitoring and managing utilization of authorized home and community-based services. Conflict free Case Management assists to restrict conflict of interest by separating Case Management from Direct service providers.

Procedures:

1. Case managers will capitalize on self-care capability and informal support whenever feasible, and family care will be supplemented rather than replaced. Case managers will facilitate informal support with training and equipment as necessary.
2. At the site's admission committee, the case management team (including the medical director) will review recommendations to ensure the appropriateness of each service category; generally, least restrictive setting or service to achieve goals is preferred by members and is often less costly.
3. Sites will work to maintain function and overall health by addressing areas that may lead to increased impairment and higher HCBS costs – effective medical care, adequate housing, Care Plan goals (nutrition, medication adherence, etc.).
4. Case managers will use creativity in developing Care Plans, employing community resources other than Medicaid-reimbursed services that will contribute to meeting Care Plan goals.

5. Sites will maintain case manager awareness of the relationship between age and/or progressive illnesses and the increased need for paid services; case managers will develop initial Care Plan that are sufficient to meet goals but do not have extra capacity, to ensure that members may receive additional services if their level of impairment or informal support changes.

6. Sites will benchmark service plan costs by level, according to site averages or using information provided by the Department of Community Health for all SOURCE Case Management Provider.

7. Upon admission, sites will calculate service plan costs for comparison to the benchmarked standards.

8. Outliers will be reviewed further by the medical director, site manager and case management supervisor. Adjustments to service plans will be made when appropriate; balancing costs of care with achieving program and Care Plans goals.

9. Sites will develop an internal method for the ongoing identification of outliers that exceed benchmarked standards established by the site or by DCH. Triggers may be service costs, units of service, etc.

10. Services costs between up to $5000.00 should be evaluated locally by the Case Management Agency. Cost estimates exceeding the DCH established $5000.00 per month threshold must be approved by DCH Case Management specialists prior to the Care Plan implementation.

11. Upon completion of enrollment and initiation of services, case manager will provide the following documents to all community service providers:

- The MDS-HC with Medication List, and the MDS-HC Participant Form
- SOURCE Level of Care and Placement Instrument (must contain required signatures and date of signature)
- Level of Care Criteria Form
- The SOURCE Care Plan, Service Order, and Care Plan task lists
- Rights and Responsibilities
- Advance Directives if available to Case Management
- Directions to the member's home, starting from the local Source site Office to the member's home address
- Consent for Enrollment for initial and annual enrollment
- SOURCE EDWP Notification Form (ENF) (only when member has notable changes)

24-Hour On-Call

Management Provider will maintain a 24-hour a day/seven days per week/365 days per year on-call system that will:

- Optimize primary medical care for members by offering prompt attention to clinical complications or illness
- Assist members and informal caregivers in addressing after-hours service delivery issues promptly
- Help members avoid unnecessary emergency room visits by medical triage and advice

All sites will maintain a 24-hour phone line answered by a live voice.

a) At assessment, the case manager will leave for the member written information on how to contact the SOURCE Enhanced Case Management, including the 24-hour phone number.

b) Education for members by the Case Manager on using the 24-hour line will be included at the assessment home visit.

c) Access to the following services will be provided or facilitated via the 24-hour phone line:

(1) After-hours medical triage and advice
(2) After-hours medical consultation by SOURCE Primary Care Provider or designated qualified medical professional
(3) Assistance in resolving service delivery complications, after hours
(4) Authorization of medical services

d) Authorization of community services including increase or decrease in service (also using the site-specific SOURCE number) must be approved by Case Management staff, with confirmation on the appropriate forms.

Member Discharge

Discharge **Planning** Policy Statement:

Discharge planning is instituted at the beginning of the SOURCE participation to assist a client in making the transition from one service environment to another.

Discharge planning is conducted to: Plan for continuity of an individual's health care; Maintain the individual's level of functioning; Lower an individual's readmission rates to medical facilities (for example: handrails in bathroom to prevent falls)

Process for Discharge **Planning**:

Complete the following activities at enrollment to ease planning at discharge:

Begin to develop the discharge plan during the initial assessment (document what the member will need if discharged)

Reflect discharge planning in care plans by utilizing the steps in 1890 that ensure maximize funding (i.e. keep family resources in place, use community resources)

Coordinate discharge planning in consultation with the client's physician, other involved service agencies, and other local resources available to assist in the development and implementation of the individual's discharge plan.

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See Discharge checklist form for more Information on operationalization of discharge planning.

Discharge Policy Statement:

SOURCE Members can be discharged for a variety of reasons. Voluntarily/Involuntarily. SOURCE supports and when possible improves the member's functioning. If evaluation or occurrences support discharge, SOURCE will work to make the transition as smooth as possible.

Process for Discharge:

The Case Manager will exhaust all means to ensure that members continue their enrollment in the program, for several key reasons:

- Members constitute a vulnerable population due to chronic illness, disability, advanced age and low-income
- Managing non-compliance is a core function of the CM/Primary Care Provider team
- DCH expects sites to meet or exceed consumer expectations

Discharge from the program may be either voluntary or involuntary. Reasons for discharge include:

- Member moves from the site's service area
- Member does not meet eligibility using the definition in section 1884 disability and Intermediate Nursing Home Level of Care Criteria
- Member is no longer eligible for full Medicaid
- Member death
- Member transfers to another waiver program
- Member is admitted to a nursing home (may hold for 100 days)

- Member Choice
- Member is chronically non-compliant (non-compliance includes continued abuse of alcohol or drugs)
- Member health and safety needs cannot be met in the community
- Member's health and functionality is not confirmed by the Primary Care Provider's documentation or other appropriate physician specialist

This section is appended by Section 1890, Right to Appeal.

a) Voluntary Discharge
Enrollment in SOURCE is strictly voluntary. Case Managers will make all feasible efforts to meet the reported and observed needs of persons in service. However, a voluntary discharge will be effective immediately as of the date requested by the member, guardian or custodial caregiver.

Procedures:

(1) A Case Manager's efforts to reconcile the source(s) of a member with the program may include as indicated:
- Conferences with providers, Case Manager and members/ Caregivers
- Changing provider, PCP or Case Manager
- Discontinuing an individual service or otherwise altering the Care Plan

(2) If efforts to resolve a member's or caregiver's dissatisfaction with SOURCE are unsuccessful, the consequences of disenrollment from SOURCE will be explained:
- Case Management services from site discontinued
- Community services reimbursed by SOURCE discontinued

(3) If other HCBS programs are enrolling the member following discharge from SOURCE, the Case Manager will work to make the transition happen smoothly.

(4) Services reimbursed by SOURCE will be discontinued effective on the date so requested by the member, or the date the member becomes ineligible.

(5) Upon learning of an effective discharge date, the Case Manager will notify:
- SOURCE providers, by completing the Discharge section of the EDWP Notification Form (ENF)
- Providers not reimbursed through SOURCE
- The SOURCE PCP office

(6) The member's PCP may continue providing primary care services following discharge from the program if requested by the member and agreed to by the PCP.

(7) Upon discharging the member, the Case Manager will complete the SOURCE Discharge Summary Form in its entirety, and Form 5382 EDWP Discharge Form to be mailed to the member and to be filed in the member's chart. **Once discharge of services occurs, make sure the Service Prior Authorization lines are end dated.**

SOURCE MEMBER INVOLUNTARY DISCHARGE

I. Involuntary Discharge

The Effectiveness of SOURCE services depends heavily on the participation of members/caregivers in developing and implementing the Care Plan, Service Order, and task lists.

A prolonged or repeated pattern of deliberate non-compliance may result in involuntary discharge of the member from the SOURCE waiver program. However, a member's involuntary discharge from the SOURCE wavier program will not end the member's Medicaid eligibility.

Some examples of non-compliance will include, but are not limited to:

- A failure of the member to keep scheduled Primary Care Provider appointments
- The member actively or intentionally avoiding or refusing Case Manager visits or other contacts
- The member's refusal to allow and/or facilitate the delivery of community services as agreed on in the Care Plan.
- A failure by the member to provide essential information affecting SOURCE's ability to help members live in healthy and functionally independent ways
- A member who refuses to participate in problem solving discussions and efforts with Case Manager's, PCP's, physicians or providers around Care Plan variances, delivery or clinical issues
- A member's failure to use designated SOURCE providers or affiliates for services

Only after thorough efforts by the site to resolve any patterns of non-compliance of the member will SOURCE waiver programs benefits be sought to be involuntarily discharged.

Discharge will occur when:

1. The case manager determines that the member is no longer appropriate or AHS deems ineligible for services under SOURCE

2. DCH staff recommend in writing that a member be discharged from service

3. Member/member's representative consistently refuses service(s)

4. Member's physician orders the member's discharge from SOURCE

5. Member enters a medical facility. (The provider may decide to send the notice of discharge immediately upon the member's placement in a medical facility or in the case of facility admission expected to be 100 days or less the Case Management Agency may suspend the Service Prior Authorization, Assessments, Care Plan, etc.)

6. Member allows illegal behavior in the home; or member or others living in the home have inflicted or threatened bodily harm to another person within the past 30 calendar days.

7. Member/member's representative or case manager requests immediate termination of services. The provider must document in the member's record the circumstances that led up to termination.

8. Member moves out of the planning and service area to another area not

served by the provider. (If requests a transfer of services, this needs to be coordinated by case management to ensure continuity of care)

9. Member expires.

10. Provider can no longer provide services ordered on the Care Plan. (see also section 1306 Discharge… initiated by the provider)

11. Member is non-compliant. Examples of non-compliance includes:

    a. Failure to keep scheduled Primary Care Provider appointments
    b. Avoiding or refusing Case Manager visits or other contacts
    c. Refusal to allow or facilitate the delivery of community services as agreed on in the Care Plan.
    d. Failure to provide essential information affecting SOURCE's ability to help members live in healthy and functionally independent ways
    e. Refusing to participate in problem solving discussions and efforts with Case Manager's, PCP's, physicians or providers around Care Plan variances, delivery, or clinical issues
    f. Failure to use designated SOURCE providers or affiliates for services

II. Procedures for Discharge:

For a member to be involuntarily discharged the following must occur:

1. The assigned Case Manager will communicate clearly at admission the program's expectations of members/caregiver

2. The Case Manager will state that program eligibility requirements and reevaluation is needed to remain on the SOURCE program

3. Single, minor, or isolated instances of non-compliance will not result in formal action; the Case Manager will address these issues with members/caregiver as they occur.

4. The Case Manager will take steps indicated for repeated instances of non- compliance, involving as indicated the member's PCP, supervisor or program manager.

5. Issues of non-compliance and efforts at resolution will be documented in the member's case notes, on the Care Plan.

6. The multidisciplinary team staffing the admissions process will be the entity to hear, explore and decide issues of pending discharge due to non-compliance

7. The Primary Care Provider will be informed of pending involuntary discharge prior to the disenrollment's effective date. Prior to discharge, a member (or custodial caregiver or guardian) will receive from the Case Manager – following approval by the site's multidisciplinary group – written warning of potential discharge with a suggested course of action required to avoid discharge.

8. For members/caregiver unable to read, the Case Manager will read the letter over the phone or in person; the letter will also be mailed to the member's house.

9. Should the first written warning fail to resolve a pattern of non-compliance, members (or custodial caregivers or guardians) will receive from Case Manager (with approval from the multidisciplinary group) a written deadline for the course of action necessary to avoid discharge.

10. If the member fails to meet the letter's deadline, the Case Manager will initiate steps to discharge.

11. The Case Manager will make referrals to other programs or agencies if the dis- enrolling member so requests.

12. The Case Manager will facilitate the transition to other agencies in all ways possible.

13. Members will be informed in writing using the EDWP 5382 Form of the formal date of discharge from SOURCE.

    Members may further seek to appeal an involuntary discharge through the Department of Community Health's appeal process**.**

    Members may be involuntarily discharged immediately from SOURCE by the site's multidisciplinary staff group for criminal activities by member or in the home, and physical aggression toward providers, CM or PCPs, by member or in the home environment bypassing procedures 3 through 13.

    Upon discharging the member, the CM will complete the SOURCE Discharge Summary Form in its entirety to be filed in the member's chart.

    Level of Care PAs will not be terminated and left open until they expire.

    End date all the Service Prior Authorization lines with appropriate date.

III. Procedures for Suspension of Service Prior Authorization

For suspension of services which will allow a member's Service PA to be reactivated and maintain LOC Prior Authorization the CM and PA builder should take these steps:

1. End date all Direct Service Provider (DSP) Lines with the date the member entered the Medical
2. Facility (please do this after checking to make sure DSP billing dates are in alignment with the end date desired)
3. Leave Case Management Service line date to mirror Service Prior Authorization end date. (This will signal to AHS that the Case Management agency has not terminated the member. Member is in suspense)

Right to Appeal

A. SOURCE members and applicants have the right to appeal the following actions of a SOURCE Enhanced Case Management site:

1. The DON-R score (but may not appeal agency refusal to screen assess based on initial information)

2. Denial of eligibility (category of eligibility other than SSI or Public Law or no category; failure to

meet nursing home level of care; refusal based on other factors like service area, available housing, safety concerns, etc.)

3. Reduction in services (any reduction in service, even resulting from a temporary increase)

4. Termination of services (discharge from SOURCE)

The Department of Community Health will notify sites when a request for an appeal is made, and when a request is made to maintain services at the current level.

B. Agencies are not to reassess a client while the client is under an appeal request or Request for Fair Hearing (RFH) unless;
   1. Greater than nine (9) months since last assessment (waiver requires annual assessment) and appeal if for a reduction of services or termination for an action other than Level of Care Denial
   2. Requested directly by an Attorney from DCH Legal Services Department

Sites should note that this policy applies only to SOURCE-reimbursed services.

Procedures for Issuing Discharge Notice from Case management Agency for other than Level of Care Denial from Alliant:

Case managers and CM supervisors will attempt to reach consensus with members and potential members (or legal guardians if applicable) on decisions made about the member's care. SOURCE sites will involve the primary care physician and/or Medical Director in all decisions resulting in adverse action.

Members who fail to meet the eligibility criteria at screening will be reviewed by the Interdisciplinary team prior to issuance of the A Denial, Termination, and Reduction in Service form 5382. The screening nurse will present, or, at a minimum, be available to answer questions about the member's DON-R to the interdisciplinary team for review and discussion.

If the team agrees that the member does not meet eligibility, the Medical Director will indicate same in item 34 of SOURCE Level of Care and Placement Instrument and sign his/her name as required.

1. Following discussion of an action falling into any of the categories described above, the site will inform the member clearly of the action to be taken.

2. Sites will give the member written notice, sent via Certified Mail, of actions for any of the categories, using the NOTICE OF DENIAL, TERMINATION, and REDUCTION IN SERVICE. The form will be dated the day the form is mailed.

3. Sites are not to issue a discharge letter if AHS has issued the decision. Sites may download AHS's written notice from the AHS web portal and take to client if client is not aware of notice or has not received notice through mail.

4. The original Denial, Termination, Reduction of services letter is mailed to the SOURCE member via Certified Mail, along with the Notice of Right to a Hearing form. After conferring to the member, the Discharge Summary is completed. A copy is kept in the SOURCE chart.

For members concurring with the intended action, the same procedure is followed.

5. Members have 30 days from the date of their EDWP Discharge Form 5382 to request a hearing in writing; in cases of decreasing or terminating services, members may retain their services at their current level by notifying DCH in writing within thirty days of the EDWP Discharge Form 5382 date. Services remain in place pending the outcome of the Administrative Hearing.

6. **(***Discharge to nursing home does not require a 30-day waiting period after the "Z" (Discharge, Termination) letter is sent; once Case Management decides it is appropriate to discharge the NH member from the Waiver, it is immediate. Refer to Section 1405-Involuntary Discharges*)

7. Case managers should follow up the EDWP Discharge Form 5382 with a call within 15 days to determine if the member (or legal guardian if indicated) has any questions concerning the adverse action notice. (See Step 3 if member has not received notice)

8. If the member wishes to appeal, the case manager should assist with their request for a hearing as appropriate.

9. The case manager should ensure the member has information on obtaining assistance in appealing an action (see EDWP form 5381, Notice of Right to Appeal Decision).

10. The Case Manager will check with the member and/or family representative regarding the notice of adverse action and whether a hearing request has been filed with DCH before formally discharging the member from the program.

11. Members requesting discharge from SOURCE are exempt from the 30-day waiting period. Case Managers should immediately send in a SOURCE Level of Care and Placement Instrument form with the date requested for discharge by the member. The member will no longer receive SOURCE EPCCM or community-based services as of the date indicated on the SOURCE Level of Care and Placement Instrument. See also Policy No.1405 (a) Voluntary Discharge.

12. A SOURCE member has the right to represent him/herself or have an attorney, paralegal or any other person to represent him/her. Case managers should notify members of the availability of local services for legal assistance to older or low- income persons.

13. If an appeal is filed by the members, the site will present information at the appeal supporting the adverse action taken.

14. Additionally, the Interdisciplinary team, with the case manager, will view other resources to meet the member's needs. Appropriate discharge planning and referral assistance will be provided to the member by the case manager throughout the thirty-day notification period.

15. CM will notify member of the planned discharge and provide the member with information regarding the appeal process, as directed in Medicaid Part I Policy and Procedures section 500.

NOTE: Prior to review by the Interdisciplinary team, the nurse (RN or LPN) shall review the member's diagnoses, medications, treatments with the member's PCP to ensure concurrence with Member's health and functional status as documented on the MDS-HC.

Procedures after decision Alliant Level of Care Denial:

1. SOURCE assessment nurse (R.N. or LPN) will carry out the MDS HC assessment and the RN will upload the assessment packet to Alliant Health Solutions. If AHS determines that the member does not meet eligibility, the denial letter will be issued to the member from Alliant . The Denial Letter states why the member does not meet the LOC criteria and cites applicable policy. The member has thirty (30) days to request a hearing.

2. Discharge planning information/resources are sent to the member within 15 days of denial.

3. A second level review option is available to members who have a AHS issued denial. This means that:

    a. If the member provides new information in the 10 days, they will either be accepted by AHS for LOC, or they will receive a 2nd and final denial letter.
    b. The member will have 10 business days to provide new information to AHS through their Case Management agency.

c. If the member provides new information in the 10 days, they will either be accepted by AHS for LOC, or they will receive a 2nd and final denial letter.

d. If the member does not give new information, no new denial letter will be issued from AHS. The member continues to have the right to ask for an appeal 30 days from issuance of the original denial letter

4. If the member requests a hearing, the member will send his/her hearing request to DCH Legal Services.

5. Upon receipt of the hearing request, DCH Legal Services will decide to accept or reject the request for hearing. If accepted DCH will:

6. Send the member a confirmation letter that the hearing will be granted,

7. Contact AHS to request a copy of the file/records used to make the eligibility determination,

8. Documentation of paperwork from steps 4 or 5, AHS confirmation, or a memo from DCH SOURCE confirming the hearing request was granted will confirm that Level of Care is to be continued under the DCH Legal Services authority (and services are to continue) for Utilization Review or Program Integrity. A copy must be sent to the providers for their records to continue services.

9. SOURCE Program site or AHS will provide a copy of the records to DCH Legal Services.

10. The benefits must continue.

11. If member's Prior Authorization has expired, AHS will extend the LOC PA for four (4) months if they have denied the member.

12. If the hearing is withdrawn with an agreement for a referral to another waiver, the new LOC PA will be approved for an extension and the new LOC must be signed by the Medical Director.

13. Upon receipt of the records, DCH Legal will assign the case to an attorney and transmit the case to OSAH for a hearing. OSAH will issue a notice of hearing setting a specific hearing date, time, and location.

14. While waiting for the hearing to occur, the benefits must continue, and monthly and quarterly contacts must be made.

15. During this waiting period, if the member decides that he/she does not want to proceed with the hearing, it is the member or the member's representative's duty to inform DCH And OSAH that the member no longer wishes to proceed with the hearing. SOURCE does not represent the member. SOURCE is not an agent of the state. The right to a hearing

belongs to the member.

16. If the member decides to proceed with the hearing, the administrative hearing will occur and the administrative law judge will issue a decision. Continue member benefits pending the judge's decision.

17. If the judge rules in favor of DCH, the member's benefits will be terminated. The member can appeal to the next level. Keep ruling with member file.

18. If the judge rules in favor of the member, the benefits will continue and DCH can appeal to the next level. Maintain a copy of the ruling with the most current SOURCE Level of Care and Placement Instrument. Annual Reassessment following an appeal is determined by the Prior Authorization dates. The time spent in hearing will count to the annual review.

Note: In the case of SOURCE terminations upheld through hearing, or in the case of voluntary terminations, SOURCE case management agencies notify all HCBS provider agencies involved in the provision of services to the member in order to avoid continuation of services not reimbursable under Medicaid.

IF	THEN
Technical Denial	When part of the required paperwork in not uploaded, you receive a technical denial.
Final Technical Denial	***This is rendered when the paperwork not uploaded within 30 days***
Initial Approval	When the LOC is complete and meets Level of Care criteria upon nurse review
Initial Decision/Denied	Rendered when the LO is complete but does not meet the level of care/policy guidelines upon initial nurse LOC review.
Second Level Nurse Review	Member may request a reconsideration of this decision by sending additional medical information to the Case Management office within 10 days of the date of the Notice of Denial/ Termination and within 20 calendar days to Alliant.
Approval/Denial	Standard approval is issued if based on the new information submitted the client meets the Level of Care criteria. A denial is issued if the based on the new information still does not meet LOC criteria
If a denial is issued by Alliant and client wants to appeal the decision	If the client requests, either orally or in writing, appeal of decision within 10 days of the date of the notice of adverse decision by Alliant, and requests that services continue while hearing is pending, services will continue until there is an administrative decision. Client must request an appeal in writing within 30 days of the date of notice of the adverse action, Send letter to:

	Department of Community Health Legal Department 2 MLK Jr Ave. SE, Twin Towers East, 18th Floor Atlanta, Georgia 30334
If a denial is issued by Alliant and the client does not choose to appeal	Then services will continue until the current level of care expires.
Legal accepts the appeal letter, the current PA will be extended for 4 months.	Alliant will extend the current LOC PA for another 4 months. The Physician notification letter and order for extended services is sent to the Physician or signed by the Medical Director at the next team meeting. Case Management will end the Service PA and build a new one for the four months of the hearing extension.

Confidentiality of Member Information

Integration of care for chronically ill people requires significant sharing of information between key players. To a greater extent than conventional HCBS, SOURCE Case Management Provider access, review and maintain patient records of all types, due to:

- Increased accountability standards for CM, across all treatment settings
- Coordination with participating primary medical care providers
- Formal linkages with health system providers

Ensuring appropriate access to medical and case management information by individuals involved in direct care or in monitoring care must be balanced with concern for member privacy. Offenses of confidentiality fall into two categories: **unauthorized access** of confidential data (looking at a member's chart or other data when there is no "need to know)," and the **unauthorized use, dissemination or communication** of clinical or other confidential data.

SOURCE Case Management Providers are required to act in accordance with the Health Insurance Portability and Accountability Act (HIPAA).

Procedures:

a) Each site will maintain a confidentiality policy specific to the organization.

b) The site-specific policy will include an "Employee Statement of Confidentiality" with disciplinary actions described for policy violations.

c) Upon admission, all members will sign a consent form to permit the release of information, as necessary to individuals or entities participating in the program.

d) Only case management, medical records and administrative staff will have direct

access to member charts, excluding regulatory agency staff.

e) Charts will be maintained after hours in a secure environment.

f) Release of information to participating providers will be only on an as needed basis, and according to the policies and procedures of the site and DMA.

g) All charts will be maintained per the guidelines as specified in Part I Policies and Procedures for Medicaid/Peachcare for Kids

Non-Reimbursed Items and Services

In helping members continue residing in the community, CM will frequently discover needs for items or services not covered by conventional third-party payers like Medicaid or Medicare or by other traditional community resources. Often these items or services are critical to achieving Care Plan outcomes for members, but the costs may be far out of reach for the member/caregiver to pay for privately. Sites will develop or have access to funds to bridge gaps in coverage for essential items or services. Typical examples include incontinence supplies, nutritional supplements and certain prescription medications; other examples are moving expenses, pest control, specific pieces of DME, etc.

If funds for non-covered items or services do not exist in the local community, a site may consider applying to local charitable foundations, accepting donations from civic organizations, individuals, churches, and other faith-based organizations, etc., to build a fund. Sites must comply with all applicable local, state and federal requirements.

Payment for such items or services by the site does not set a precedent for such funding for all members. Consideration should be on an individual, case-by-case basis and will depend on the amount of funding and guidelines established.

Procedures:

a) The Case Manager will review any available options to cover a needed item or services, including the member/caregiver's own resources.

b) When other potential sources are ruled out, the Case Manager will submit a request in writing to the Case Manager Supervisor documenting specifically the service or item needed a time frame if applicable and a brief rationale.

c) The Case Manager Supervisor or Program Manager will have authority to approve the expenditure and will maintain a record of all items/services covered.

d) The Case Manager will forward the approved request to the organization or staff member (if internal) in charge of dispersing funds.

e) If the items/services are not approved, the Case Manager will continue to work with the SOURCE member/Caregiver to attempt to obtain the item or services from

other sources or to find a suitable substitute.

f) For items/services funded on an ongoing basis, the Case Manager assigned will be responsible for reviewing every quarter the need for continued assistance.

g) Non-reimbursed services for members will be documented, for potential analysis of service packages.

HIPAA Regulations

A federal law about health care, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), provides new health privacy regulations.

The Privacy Rule under HIPAA establishes privacy protections that assure Medicaid recipients and all health care patients that their medical records are kept confidential. The rules will help to ensure appropriate privacy safeguards are in place as we manage information technology to improve the quality of care provided to patients. The new protections give recipients greater access to their own medical records and more control over how their personal information is used by their health insurance plans (including Medicaid) and by health care providers.

The DCH Notice of Privacy Practices explains how Georgia Medicaid uses and discloses individuals' health information and how individuals may access their information. The notice was mailed to all Medicaid recipients with the April 2004 eligibility cards.

Case Management Reimbursement Hierarchy

Note: Duplication of Case Management Services

Federal policy and the Department of Community Health (DCH) prohibit the reimbursement for repetitive case management services to more than one agency or Medicaid provider that renders case management services to an individual.

- A hierarchy (see below) for case management services was established to prevent payment of more than one case management services per month.

1. COS 830 – CMO
2. COS 930 – SOURCE
3. COS 680 - MRWP/NOW
4. COS 681 - CHSS/COMP
5. COS 660 – ICWP
6. COS 590 – CCSP
7. COS 764 – Child Protective Services Targeted Case management
8. COS 800 – Early Intervention Case Management
9. COS765 – Adult Protective Services Targeted Case Management

10. COS763 – At Risk of Incarceration Targeted Case Management
11. COS762 – Adults with AIDS Targeted Case Management
12. COS790 – Rehab Services/DSPS
13. COS100 – Dedicated Case Management – Non-Waiver Members
14. COS840 – Children's Intervention Services

Effective for dates of service on and after January 1, 2009, the Case Management agency or Medicaid Provider submitting claims for the same member in the same calendar month:

- If two claims are submitted for CM services the hierarchy determines which provider will be paid.
- If the lower hierarchy provider has been reimbursed the claim amount will be recovered and payment made to the CM provider first in the hierarchy.

Standard of Promptness Guidelines/SOURCE – below (see 1836 for additional SOP)

IF ACTIVITY IS	THEN STANDARD OF PROMPTNESS IS WITHIN
Responding to telephone inquiry regarding SOURCE admission	24 hours after telephone inquiry
Screening a referral	3 business days after telephone inquiry
Nurse completion of face-to-face assessment for new admissions	Within 15 business days of notification of slot availability
RN review of the initial and recertification assessment	10 business days following the assessment visit
Sending assessment /reassessment package to AHS for LOC review	Immediately following RN Review
Send ECM DM Physician Letter to PCP	Following approval of PA by AHS and every 6 months after
Telephone contact with member	Monthly
Face to Face Care Plan review	Prior to 30th day after initial LOC approval and then quarterly
Submitting Monthly Statistical Reports to DCH	By the 15th of the month following the month subject to report
Complete and provide a copy of the discharge plan with specific resources to the member	No later than 15 days following a SOURCE involuntarily discharge (day of notification by AHS or date the CM agency issued letter to member)