ALABAMA MEDICAID AGENCY
POLICY AND PROCEDURE MANUAL

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CHAPTER 1

PROGRAM ADMINISTRATION

The Alabama Medicaid Agency (AMA) with the oversight of The Centers for Medicare and Medicaid Services (CMS) is responsible for administration of the home and community-based service (HCBS) waivers.

A. CENTERS FOR MEDICARE AND MEDICAID SERVICES

1. CMS is a federal agency within the Department of Health and Human Services that is responsible for the oversight of administering Medicaid and Medicare programs. The central office is located in Baltimore Maryland, and the states are divided into regions. The state of Alabama is located in Region IV.

2. Any new waiver requests are submitted to the central and regional offices for approval. If an HCBS waiver requires an amendment to its originally approved contents, submission is sent to the regional office for approval. A contact person for the home and community based waivers is assigned in each region. CMS staff is responsible for making sure the waiver is implemented and administered according to the waiver document and all assurances are being met. The CMS 372 report is submitted on an annual basis and is used to determine whether or not the program is meeting the client's health care needs, the client's health and safety is being safeguarded and that the program is cost effective. CMS also conducts compliance reviews. The review schedule and activities are coordinated with the AMA Long Term Care Division. During the review, the representatives interview waiver participants, providers and State Medicaid staff who perform duties applicable to the operation and monitoring of the waiver. These are usually done during the year prior to the expiration of the waiver.

B. ALABAMA MEDICAID PROGRAM

1. Medicaid was created in 1965 by congress along with a sound-alike sister program, Medicare. Medicare is a health insurance program primarily for elderly persons, regardless of income. It is financed through Social Security taxes and premiums. Medicaid is jointly financed by the state and federal governments and is designed to provide health care to low income individuals. Medicaid started in Alabama in 1970 as a Department of Public Health program. In 1977, the Medical Services Administration was made an independent state Agency. In 1981, it was renamed the AMA.

2. The AMA administers the state Medicaid Program as directed by the governor. The head of the agency is the Commissioner, who serves at the pleasure of the Governor. Medicaid also serves as the administering agency in the waiver programs. The Long Term Care (LTC) Division in collaborative effort with other

state agencies, is responsible for administrative oversight of the waiver. A list of contact persons in the LTC Division can be found in the Appendix A Section or on the Medicaid Website, www.medicaid.alabama.gov

3. A description of the State Plan services offered through the AMA is found in the Appendix A Section of this manual or on the Medicaid Website, www.medicaid.alabama.gov.

C. FISCAL AGENT

1. The AMA contracts with a fiscal agent to process and pay all claims submitted by providers of medical care, services, and equipment authorized under the Title XIX State plan. The current fiscal agent is Hewlett Packard (HP).

2. EDS is responsible for enrolling providers in the Medicaid program and for maintaining provider information in the Alabama Medicaid Management Information System (AMMIS). They are also responsible for preparing and distributing provider billing manuals to providers of Medicaid Services for guidance in filing and preparing claims. The fiscal agent's Provider Inquiry Unit, through provider representatives is available for technical assistance and education to Medicaid providers of service. Providers with questions about claims should contact them directly for assistance. Please see the Medicaid_Website, www.medicaid.alabama.gov, for contact information.

CHAPTER 2

HOME AND COMMUNITY-BASED WAIVERS

Home and Community Based Services (HCBS) is one of the most popular Medicaid options available to states. Authority to grant waivers was provided by section 2176 of the Omnibus Budget Reconciliation Act of 1981, which added Section 1915(c) to the Social Security Act. Under Section 1915(c) of the Social Security Act, the Centers for Medicare and Medicaid Services waived certain statutory requirements to allow a state to cover a broad array of HCBS as an alternative to institutionalization. In other words, the Waiver "waives" existing rules of the Social Security Act. It is beneficial as it allows the client to receive services in the home. It gives the client a choice between institutional care and waiver services. The waivers must define a distinct population, define a level of care, and be cost-effective in preventing institutionalization. Under this statutory authority, waivers are granted for an initial term of three years. Upon the state's request, the waiver may be renewed for an additional five-year period.

The State develops the waiver proposal and submits it to CMS for approval. The state of Alabama has developed six HCBS waivers that provide alternatives to institutionalization for some Medicaid recipients. The waiver programs are aimed at helping recipients receive extra services not ordinarily covered by Medicaid in this state. HCBS programs serve the elderly and disabled, mentally retarded, and disabled adults with specific medical diagnoses. These programs provide quality and cost-effective services to individuals at risk of institutional care.

Alabama's HCBS Waivers are the: Elderly and Disabled Waiver (EDW), Intellectual Disabilities Waiver (IDW), State of Alabama Independent Living Waiver (SAIL), Living at Home Waiver (LHW), HIV/AIDS (530) Waiver, and the Technology Assisted Waiver for Adults (TAW). The information in this manual will be specific to the EDW.

A. ELDERLY AND DISABLED WAIVER

1. The EDW Program provides home and community-based services to assist elderly and disabled individuals to live in the community who would otherwise require nursing facility care. The EDW was initially approved by the CMS effective October 1, 1982. The waiver is granted under provisions of Section 1915(c) of the Social Security Act. The current waiver was approved for a five-year period that began October 1, 2007-September 30, 2012.

2. The Alabama Department of Public Health (ADPH) and the Alabama Department of Senior Services (ADSS) serve as the operating agencies (OA) and they are responsible for the day-to-day operations of the program. This includes: managing the program by focusing on improving care for the client, protecting the health and welfare of the client, giving the client free choice of providers and waiver service workers, and making sure all direct service providers meet the qualifications as outlined in the waiver document.

3. The AMA's Fiscal Agent assigns the OA provider numbers. The provider numbers are used to identify the OA and for claims processing. The provider numbers assigned to the EDW Program are 1871636563 for ADPH and 1326111337 for ADSS.

4. The operating agencies and providers of direct services shall furnish any recipient, program or provider information to the AMA upon request.

5. To participate in the EDW program, direct services providers must meet all provider qualifications, licensure, and certification requirements as outlined in this manual and the EDW document.

B. WAIVER REQUIREMENTS

The waiver defines the target population and the related eligibility criteria; gives assurances regarding program operation; lists the services to be provided, including the definitions of those services, provider qualifications, and anticipated utilization; estimates the numbers to be served and the related costs; compares waiver costs to institutional costs to demonstrate cost-effectiveness; and gives other information about program administration. The waiver may be amended with the approval of CMS.

C. ASSURANCES

In order to receive waiver approval and comply with Federal Regulations that cover waivers, the AMA must make the following assurances to CMS for every HCBS waiver that is approved and implemented. Violation of these assurances could result in the termination of the waiver.

The AMA provides the following assurance to CMS:

1. Necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. Those safeguards include:

   (a) Adequate standards for all types of providers that furnish services under the waiver;

   (b) Assurance that the standards of any State licensure or certification requirements are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements will be met on the date that the services are furnished; and

   (c) Assurance that all facilities covered by Section 1616(e) of the Social Security Act, in which HCBS will be provided, are in

compliance with applicable State standards and meet the requirements of 45 CFR Part 1397 for board and care facilities.

2. The Agency will provide for an evaluation and periodic reevaluations at least annually of the continuing need for the level of care.

3. When an individual is determined to be likely to require nursing facility level of care and is included in the targeting criteria, the individual or his or her legal representative will be:

   (a) Informed of any feasible alternatives under the waiver; and

   (b) Given the choice of either institutional or HCBS.

4. The Agency will provide an opportunity for a fair hearing, under 42 CFR Part 431, subpart E, to persons who are not given the choice of HCBS as an alternative to institutional care or who are denied the service(s) of their choice, or the provider(s) of their choice.

5. The average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures for the level(s) of care indicated in of the waiver document of this request under the State Plan that would have been made in that fiscal year had the waiver not been granted.

6. The Agency's actual total expenditures for HCBS and other Medicaid services under the waiver and its claim for Federal Financial Participation (FFP) in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred by the State's Medicaid program for these individuals in the institutional setting(s).

7. Absent the waiver, persons served in the waiver would receive the appropriate type of Medicaid funded institutional care that they require.

8. The Agency will provide CMS annually with information on the impact of the waiver on the type, amount and cost of services provided under the State Plan and on the health and welfare of the persons served on the waiver. The information will be consistent with a data collection plan designed by CMS.

9. The Agency will assure financial accountability for funds expended for HCBS, provide for an independent audit of its waiver program (except as CMS may otherwise specify for particular waivers), and it will maintain and make available to HHS, the Comptroller General, or other designees,

appropriate financial records documenting the cost of services provided under the waiver, including reports of any independent audits conducted.

10. The State assures that it will have a formal system in place by which it ensures the health and welfare of the individuals served on the waiver through monitoring the quality control procedures described in the waiver document (including Appendices). Monitoring will ensure that all provider standards and health and welfare assurances are continuously met, and that plans of care are periodically reviewed to ensure that the services furnished are consistent with the identified needs of the individuals. Through these procedures, the State will ensure that the quality of services furnished under the waiver and the State Plan will be provided to waiver clients. The State further assures that all problems identified by this monitoring will be addressed in an appropriate and timely manner consistent with the severity and nature of the deficiencies.

D. TARGETED POPULATION

The EDW will be available to eligible clients in the community who meet the current institutional nursing facility admission criteria and who:

1. Are at the point of discharge from a general acute care facility, and without the availability of waiver services would be eligible for placement in a nursing facility.

2. Reside in the community, but are in danger of institutionalization, when their disabilities and level of functioning are such that, without the availability of waiver services nursing facility placement would probably occur.

3. Are residents of a nursing facility, and who opt to leave that facility because of available HCBS.

E. SERVICES

The services approved in the waiver are listed below. Please refer to Chapter 7 for service definitions.

1. Case Management

2. Personal Care

3. Respite Care

4. Homemaker

5. Adult Day Health

6. Companion Services

7. Home Delivered Meals
   (a) Frozen Meals
   (b) Shelf Stable Meals
   (c) Breakfast Meals

CHAPTER 3

ELIGIBILITY

The Alabama Medicaid Program is a medical assistance program that is jointly funded by the federal government and the state of Alabama to assist in providing medical care to individuals and families meeting eligibility requirements. Income, resources, and assets are taken into consideration when determining Medicaid eligibility.

A. DETERMINATION PROCESS

1. Medicaid eligibility is determined by policies established by and through the following agencies:

   a. SSA

   b. AMA

   c. DHR (SUP and Federal/State Adoption Subsidies)

2. Names of eligible individuals and pertinent information are forwarded to Medicaid who, in turn, makes the information available to HP. Any questions concerning general or specific cases should be directed in writing to Medicaid or the appropriate certifying agency.

3. Current eligibility for the Alabama Medicaid Program must be verified or established before admission to the EDW Program. Medicaid eligibility for Supplemental Security Income (SSI) clients is established by the SSA.

4. Medical eligibility is determined based on current admission criteria for nursing home care as described in Chapter 36 of the Alabama Medicaid Administrative Code.

   a. Potential waiver clients must be "at risk" of nursing home placement.

      An individual may be at risk of nursing home placement when:

      - The individual is deficient in one or more of the following areas: functional, health, cognitive/emotional, informal support; to the extent that it consistently places the client's health and/or safety in jeopardy of an adverse outcome.
      - The degree of dependency on primary caregivers or direct care provider of personal care increases particularly when combined with

multiple medical problems, episodes of confusion, inappropriate behavior, and/or incontinence

b. If a waiver client appears to be medically ineligible, additional medical information must be obtained from the physician or physician's staff if the physician is unavailable.

c. Every effort should be made by the case manager to discuss the medical information with the physician. The case manager can contact the physician's staff if he or she is unable to communicate with the physician. The case manager should consult with the OA's state office on difficult cases that cannot be resolved in the county office or on cases where efforts to verify medical information from the physician have been unsuccessful.

d. Special efforts should be made to discuss the level of care decision and possible alternatives with the client, responsible party, and/or significant other. The client must receive a 10-day notice prior to terminating the case. The client is notified of this determination and the date of the termination must be indicated in the letter. The client can continue to receive services through the date of termination. All appeals procedures should be explained clearly to the client.

e. All recipients applying for the EDW program who are under the age of 65 and have not been determined disabled will be required to have disability determined by Medicaid before processing the financial determination.

5. The Medicaid District Office determines financial eligibility for the other groups served through the EDW program.

a. Certain protected groups deemed to be receiving SSI are:

(1) Continuous - Those individuals who are not eligible for SSI because their income exceeds the Federal Benefit Rate (FBR) due to certain Title II COLA's received after April 1977 ("Pickle People") (42 CFR 435.135).

(2) Disabled Widow/Widower - A widow/widower between the ages of 50 and 59 who would be eligible for SSI except for entitlement to Social Security resulting from a change in the definition of disability and who is not eligible for Part A Medicare (P.L. 99-27251202 and P.L. 100-203, S 9108).

(3) Disabled Widow/Widower - A widow/widower between the ages of 60 and 65 who lost SSI as a result of receiving Social Security and who is not receiving Medicare (P.L. 100-203, S9116).

(4) Disabled Adult Child - An individual who lost their SSI benefits upon entitlement to or increase in child's insurance benefits based on disability. These are individuals who began receiving an increase in Social Security benefits as a disabled adult child (P.L. 99-643).

b. The special home and community-based waiver group at 42 CFR 435.217 includes individuals who are eligible under the Medicaid State Plan if institutionalized.

6. DHR determines financial eligibility for the following groups served through the EDW program.

a. SUP – Individuals who are ineligible for SSI or optional State Supplements because of requirements that do not apply under title XIX of the act. (42 CFR 435.122)

b. State Adoption Subsidy Individuals – Individuals under age 21 who are under State adoption assistance agreements. (42 CFR 435.227)

c. Federal Adoption Subsidy Individuals – Children for whom adoption assistance or foster care maintenance payments are made. (42 CFR 435.145)

****Please note: State or Federal adoption subsidized individuals must have a disability determination on file to be eligible for the Elderly & Disabled Waiver.**

7. Financial Ineligibility

a. Evidence of financial ineligibility must be documented. Methods of verification include:

(1) MSIQ screen,

(2) Letter or documentation from SSA,

(3) Written verification from the Medicaid District Offices.

b. The case manager must verify a client's Medicaid ineligibility before the client is terminated from the waiver.

c. Special efforts must be made to contact and discuss possible alternatives with the client, responsible party, and/or significant other if the client requires services in the community. Referrals should be made on behalf of the client to other community agencies.

- A waiver client who loses financial eligibility for Medicaid for up to 100 days due to excess resources, lump sum payment, etc., who is still within the active redetermination period, can immediately be reentered into the waiver after financial eligibility has been reestablished and verified. The case should be handled as follows:

- The Long Term Care segment will remain open;
- A copy of the Slot Confirmation Form (Form 376) will be forwarded to the Medicaid EDW Program Manager for QA audit purposes;
- In cases where a Form 376 is not used, the client's name and Medicaid number will be forwarded to the Medicaid EDW Program Manager for QA audit purposes;
- Prior to restoring service the client must indicate their choice of community care vs. institutional care;
- The case manager must conduct a face to face visit with the client in the home;
- The case manager will complete a reassessment of the client's needs;
- A review of the Care Plan must be completed;
- An initial visit with the DSP and case manager must be completed.

If an audit by the Waiver QA Unit reveals that the above listed requirements were not met during the process of reestablishing eligibility, then a recoupment will be initiated. If the time period of financial ineligibility exceeds 100 days then the application must be processed as a readmission. During the client's period of financial ineligibility, the OA can continue services at their discretion.

8. To receive services under the EDW program an individual must meet one of the following Medicaid eligibility criteria:

a. SSI

b. SSI recipients (Protected groups deemed to be SSI recipients)

c. Institutional Deeming Category (300%)

- The institutional deeming process may be used to disregard a potential waiver recipient's parental or spousal income in the community, which may be too high thereby making the individual ineligible to receive waiver services.

- Individuals using the institutional deeming process or 300% of SSI criteria will have to complete the Form 204/205. This is a financial eligibility determination form which is reviewed and processed by the

Medicaid District Office, Eligibility Division. Form 376 (Waiver Slot Confirmation Form) should also be submitted at this time.

Note: only original copies of the Form 204/205 will be accepted. photocopies will not be accepted by the AMA.

(1) The clients in the target groups for EDW services must meet the nursing facility Level of Care.

(2) The final level of care determination will be made by Registered Nurses at the OA in accordance with Chapter 36 of the Alabama Medicaid Administrative Code. The AMA Waiver Quality Assurance Division will do a random retrospective review of EDW clients to ensure that documentation supports the medical level of care criteria, appropriate physician certification is documented, as well as other state and federal requirements.

9. The EDW will be available to eligible clients in the community based upon current institutional nursing facility admission criteria who:

a. Are at the point of discharge from a general acute care facility, and except for the availability of waiver services, the client would be eligible for placement in a nursing facility.

b. Reside in the community, but are in danger of institutionalization, when their disabilities and level of functioning are such that, without the availability of waiver services nursing facility placement would probably occur.

c. Are residents of a nursing facility, and who opt to leave that facility because of available HCBS.

10. EDW services cannot be delivered to persons who meet any of the following:

a. Reside in a domiciliary or assisted living facility;

b. Reside in a nursing facility;

c. Receive services through any other approved and implemented HCBS waiver program;

d. Have a primary diagnosis of mental illness and/or mental retardation;

e. Are not approved for the services indicated on the Plan of Care;

f. Choose nursing facility care;

g. Move to another state;

h. Refuse to sign the HCBS-1 form;

i. Whose health and safety is at risk in the community as determined by the AMA and/or the OA;

j. Are uncooperative with a provider in the provision of services;

k. Have Medicaid eligibility blocked due to transfer of assets;

l. Are in a hospital or other acute care facility;

m. Are in a hospital PHEC bed or swing bed;

n. Reside in a ICF/MR facility;

o. Receive Hospice services paid for by Medicaid;

p. Reside in a boarding home;

q. Are unable to provide a healthy and safe environment in which waiver services can be delivered;

r. Are unable to sustain an environment in which providers are treated with dignity and respect.

11. Number of individuals to be served

Each waiver program is allotted a certain number of "slots" to be filled by clients approved to receive waiver services within a waiver year. If a client transfers from one waiver to another, goes into a nursing facility, loses waiver eligibility, or expires (dies) within the same waiver year, this slot is considered "filled" and therefore may not be refilled by a different individual. This slot should remain "filled" unless the same client who had previously left the slot is refilling it. Placing a waiver client in a filled slot in any of the cases above would count as two unduplicated slots. An approved waiver participant should therefore be placed in one of the remaining available slots. Waiver slots may not be refilled until the beginning of the new waiver year.

12. Age criteria

There are no age criteria for the EDW program.

B. VERIFICATION OF MEDICAID ELIGIBILITY

1. Eligibility must be verified at least monthly. Several options are available for accessing this information. Providers may choose the option that works best for them

2. If there is incorrect information on a recipient's plastic card, the recipient should report the changes to the agency that certified him or her for Medicaid. When the certifying agency corrects the information, a new plastic card will automatically be sent to the recipient. In Alabama, the agencies that certify individuals for Medicaid are the SSA, DHR, and the AMA.

3. If a recipient loses the plastic card issued to him or her, they should call the Medicaid Recipient Inquiry Unit at 1-800-362-1504 and ask for a replacement card.

4. Claims submitted for services furnished must contain all thirteen (13) digits of the recipient's Medicaid number.

CHAPTER 4

ADMISSION AND APPLICATION PROCESS

The AMA develops criteria for admission to all home and community based waiver programs. The AMA provides training for OAs' case management staff and nurse consultants upon request. Through these collaborative efforts, applicants are screened for appropriateness of admission to the program, care plans are developed based on individualized needs, the medical level of care determinations are assessed, and recipients are linked to providers for service delivery.

A. WHERE TO APPLY

Applicants may apply through either of the OAs of the EDW program by contacting any County Public Health Department or any Area Agency on Aging in or near the county close to where the applicant resides. The OA may also receive referrals from family members, interested neighbors or friends, physicians, hospitals, nursing homes, or staff of a public or private agency.

B. INTAKE SCREENING

Prior to assessment for the waiver program, the case management staff for the EDW program screens the applicant for their desire for waiver participation and their likelihood to meet financial and level of care eligibility criteria. These activities are preliminary requirements for waiver enrollment and are distinct from case management activities but are included in this scope of service and are recorded as administrative activities. These activities are documented in the case record.

1. The intake and screening process is involved and must include documentation regarding the following:

    a. The applicant has been informed about the application process;

    b. The applicant has been informed of all direct service providers and allowed his or her freedom of choice of providers;

    c. The applicant has been informed of all HCBS programs of which he or she may benefit and allowed freedom of choice of programs;

    d. The applicant has been informed of choice options regarding case management services;

    e. The applicant must indicate a written choice between institutional or community care. The only exception to a written choice is when the client is not capable of signing the form. In this situation, approval for waiver services should not be denied if a written choice cannot be obtained. The

reason for the absence of a signed choice should be well documented in the case record. Signatures with the mark of an X are accepted followed by a statement "Mark of recipient's name" and the mark must be witnessed. If the applicant is physically impaired to the extent that he or she is unable to sign for him or herself, the legal representative may sign the form as follows: "Jack Jones signed by Joe Scott." It must be clearly documented why the applicant did not sign;

f. Documentation should also include:

(1) The setting and the persons present and the involvement of the applicant and or significant other during the assessment process;

(2) The support systems (formal and informal) that the applicant currently receives;

(3) The service needs;

(4) Emergency backup plan for those applicants who are considered "at risk" if visits are not made. (A disaster preparedness plan should also be in place.);

(5) The case manager documentation that he or she has discussed the client's rights and responsibilities with the client, responsible party, and/or significant other.

C. APPLICATION PROCESS

The Home and Community-Based Services Program Assessment (HCBS-1) is the required application developed by the AMA for support of the assessment, risk of institutionalization, and plan of care.

1. The case manager with the aid of the applicant's physician must complete the HCBS-1 application on all individuals that have been determined appropriate for admission to the program.

2. The case manager is responsible for obtaining the most reliable and accurate information available. The applicant's diagnoses and medications should be indicated on the HCBS-1 application.

3. The signature of the applicant should be present to ensure that the applicant has been involved in the care plan development and given the OA permission to share information with involved providers.

4. The physician's signature should be present to indicate that the applicant is at risk for institutional care and that HCBS will prevent or delay the need for institutional care.

5. The plan of care must include the name of the provider of services, objectives, services, frequency of services, and the start and end dates for the services. Any changes to the plan of care must be documented.

6. The HCBS-1 application must be submitted to the OA nurse consultant by the case manager upon completion by the physician. The OA nurse consultant will review the application to obtain a clear picture of the client's medical status and functional abilities**,** psychosocial behavioral status, and home environment.

7. If the information is complete and supports the above and the criteria developed by the AMA, the OA nurse consultant will approve the application. The application will be processed through the HP system. The application will have up-front edits performed. If there are no problems identified, the system will produce a LTC segment and an acceptance will be returned to the OA. The LTC segment validates approval for dates of service delivery. If the upfront edits performed identify problems, then a rejection notice will be returned to the OA with reasons for rejection. Corrections must be made and the information resubmitted to the HP system.

8. The case manager will be informed of the approval when received. The case manager will in turn provide a service authorization to the provider chosen by the recipient for the initiation of service delivery.

9. If the information on the application is not complete, the OA nurse consultant will return the application to the case manager for additional information.

D. DENIALS BY OPERATING AGENCIES

The Operating Agencies may deny an application which may include, but are not limited to the following circumstances:

1. There is no physician certification;
2. A new admission application with less than two (2) medical criteria checked on the application;

3. A request for additional necessary medical information to process the application is not received within 60 days;

4. The Operating Agency cannot safely maintain the individual in the community;

5. The waiver does not cover the eligibility group.

A letter indicating the reason for denial must be mailed to the recipient by the Operating Agency including procedures for appealing the decision by requesting an informal conference and/or a fair hearing.

E. REDETERMINATIONS

Redeterminations of the EDW clients must be performed on an annual basis.

1. The case manager must complete a new HCBS-1 application in the month that the current determination expires. The redetermination should be the same process as for the initial assessment process.

2. In an effort to balance caseloads of case managers, a redetermination may be submitted up to 90 days early for approval.

3. The HP system will not accept applications more than 45 days prior to the redetermination date unless it is marked as an early redetermination.

F. RETROSPECTIVE REVIEWS

The AMA nurse reviewers will perform a random review of all applications that are accepted into the HP system. For a more detailed description of retrospective reviews, please refer to the Quality Assurance section of this manual, Chapter 9.

CHAPTER 5

RECIPIENT UPDATE AND REVIEW

A. READMISSION

If a client has received home and community-based waiver services in the EDW Program in the state of Alabama, but has been terminated and is reapplying during the same year, the admission requirements will be equivalent to those of a new admission.

- If a client has been without direct services for over 100 days, for any reason, a readmission would be applicable.

B. TRANSFERS

1. When a client transfers from one county to another within the state within the same OA no information should be submitted to Medicaid until the redetermination is due.

   Because of changes in the new Medicaid MMIS, there is no simple and "clean" way to process waiver-to-waiver transfers or nursing home to waiver transfers that occur in the middle of the month. For this reason, there is a requirement that these transfers are processed for services to begin on the first of the next month. This process will ensure proper payment to the Operating Agencies rendering services to waiver recipients.

   The Medicaid District Office (DO) must be notified by the 15th of the month prior to the recipient's transfer to allow the DO worker time to change an existing Program Code on the system to the Program Code for services that will be rendered on the first day of the next month. If the correct Program Code is not on the system by the first of the month, payment cannot be ensured for services rendered.

   This does not apply if:
   - The recipient is a new award and there is no existing Program Code, or
   - The recipient is transferring from a waiver to a nursing home, or
   - The recipient is not certified by the Medicaid District Office, so there is no Program Code.

   For waiver participants who are not certified by the Medicaid District Office, transfers can occur as soon as practical. For example, waiver participants certified by the Social Security Administration can be transferred anytime during the month when the transfer is coordinated between the transferring OA and the receiving OA.

2. When transferring from one OA to another, the original OA should:

   a. Send a copy of the HCBS-1 application to the receiving OA

   b. Attach a cover letter to include any pertinent information about the client the receiving OA may need.

3. When transferring from one OA of services to another, the receiving OA should:

   a. Submit to the OA nurse consultant the HCBS-1 application which should include a new assessment on page 1, 2, and a new care plan on page 4, and a copy of the medical form that was previously in place.

   b. The receiving case manager should verify that there is continued medical and financial eligibility effective on the transfer date.

   c. The comments section on page 2 of the HCBS-1 application should contain information about the transfer. For example, this recipient transferred to this provider from ADPH on 8/1/01. This replaces the old instructions of writing transfer in the upper left corner of the form above the client's name.

   d. The receiving agency must agree to accept the transfer in advance. The case manager should coordinate the transfer to end on the last day of one month and start with the new OA on the first day of the next month.

C. REINSTATEMENTS OF WAIVER RECIPIENTS FOLLOWING NURSING HOME STAYS

If a client has a short stay in a nursing facility, post extended care (PEC) bed, or Swing Bed of 100 days or less and is still within the active redetermination period, the following processes should occur:

1. Once the recipient is admitted to the nursing home, PEC bed, or Swing bed, the Operating Agency must submit the waiver end date to the Long Term Care system by using the Long Term Care Notification Software indicating the recipient is discharged from the waiver.
2. Upon discharge from a nursing facility, a reassessment must be completed and services resumed within ten (10) days from the nursing home discharge date. The OA will enter a new begin date for the reinstatement by using the Long Term Care Admission Notification Software. The case manager must conduct a face-to-face visit before services are resumed.
3. The full HCBS Application must be updated, with the exception of the Admission and Evaluation Data form (Medical).
4. The HCBS plan of care start dates must be updated for all services—including case management services.

5. The course of events related to the nursing home admission and discharge should be clearly documented on the HCBS Waiver application, to the extent possible, to reflect nursing home admission date, nursing home discharge date and date the waiver services were ended and resumed. It is understood that in some instances the OA may not be notified by the family of the recipient's discharge from the nursing facility. The OA will resume services as soon as possible but not later than 10 days after notification occurs

    - A Reinstatement is not applicable if the client's total number of days that they have not received direct services (for any reason) exceeds 100.
    - Long Term Acute Care Facilities can be treated as hospital admissions as long as documentation shows that a reevaluation of the Plan of Care occurred prior to client coming back to the community and the stay is less than 100 days.
    - The "100" days includes the day of admission or discharge, not both

Waiver recipients whose redetermination period expires before the recipient is discharged from the nursing home or who fail to begin services within ten (10) days of discharge from the nursing home must be submitted as a waiver readmission.

D. TERMINATIONS

1. Termination of waiver services

    a. Services must be officially terminated if a client no longer requires or becomes ineligible to receive the service. Waiver services may be terminated at anytime during a waiver approval period.

    b. When a change in the client's needs suggests a change in services included in the client's plan of care, the case manager will discuss the proposed change with the client, responsible party, and/or significant other before implementation and/or before issuing a written advance notice. The discussion will include an explanation of the reason for the change, impact of the change, and an agreement, if possible, of the client, responsible party, and/or significant other to the change.

    c. When EDW services are suspended, terminated, or reduced to coincide with the client's justifiable need, the service definition, and/or eligibility for the service, written advance notice is required at least ten calendar days before the effective date of action, with the following exceptions:

        (1) A written statement is provided by the client, responsible party, and/or significant other which specifies that services are no longer needed or wanted and/or there is an agreement to reduced, suspended, or terminated services;

(2) The client moves to another county and EDW services are being provided in that county;

(3) The client transfers to another waiver program;

(4) The client moves out of state;

(5) The client dies;

(6) The client moved and left no forwarding address and his or her whereabouts are unknown as verified by return of agency mail;

(7) The client enters a nursing home, hospital, or other facility where services cannot be provided according to policy;

(8) The client is no longer financially eligible; and,

(9) The client, responsible party, and/or significant other request by telephone that services be reduced, suspended, or terminated.

The above exceptions are not a definitive list. If an unprecedented situation occurs the AMA should be contacted.

d. EDW services as on the plan of care at the time the notice was given are to be continued from the date of the written notice and the effective date of the adverse action unless:

(1) Providing services results in a danger to the health and safety of the service provider(s);

(2) Providing services is against the expressed wishes of the client, responsible party, and/or significant other;

(3) There is no willing provider available.

2. Noncompliant Client

a. If a client, responsible party, and/or significant other refuses to cooperate with the EDW program and all alternatives (i.e., counseling, personal contacts, referrals to interagency team staffing, case manager/supervisory visits, etc.) have been exhausted, termination of the waiver services and/or termination from the EDW program may be appropriate.

b. Examples of noncompliance include but are not limited to:

(1) Repeated refusal to cooperate with providers and/or case managers;

(2) Repeated incidences of noncompliance with the plan of care;

(3) Physical abuse or repeated verbal abuse toward provider and/or case manager;

(4) Conduct which adversely impacts the program's ability to ensure service provision or to ensure the client's health, safety, and welfare.

c. If termination of a waiver service for noncompliance is being considered, the following must occur:

(1) All efforts made in working with the client, responsible party, and/or significant other must be carefully documented;

(2) Termination of services must be prior approved by authorized staff at the OA;

(3) Client must be notified of termination of service;

(4) The service contract must be sent to the provider to terminate services.

(5) The client, responsible party, and/or significant other must be notified in writing by certified mail of the program requirements, advised of potential consequences of continued noncompliance and given an opportunity to remedy the circumstances. The letter must have the authorized staff at the OA approval prior to sending to the client.

CHAPTER 6

APPEAL RIGHTS

The AMA LTC Division is responsible for the administration and oversight of the HCBS Programs. Any Medicaid applicant or recipient has the right to request an appeal of any decision by the administering or operating agencies which adversely affects his or her eligibility status for receipt of services and/or assistance. The AMA will provide an opportunity for a fair hearing, under 42 CFR part 431, subpart E, to beneficiaries who are not given the choice of home and community-based services as an alternative to institutional care, or who are denied the services of their choice or the providers of their choice. In a cooperative effort, the State and the Operating Agencies have procedures in place to assure CMS that at the time of application due process of client rights to a fair hearing is explained to a potential client. Due process consists of a right to an informal conference or to a fair hearing if client's request for waiver services is denied, terminated or reduced.

A. TEN (10) DAY ADVANCE NOTICE

1. When services have been reduced or terminated, the case manager should send a 10-day advance notice to the client prior to the reduction or termination of services. When the client receives this notice, they have 10 days following the effective date of action taken to request an informal conference in writing.

2. The OAs are responsible for explaining the procedures when services have been reduced, suspended, or terminated under the waiver and that the written notice includes:

    a. A description of the action the agency intends to take,

    b. The reasons for the intended action,

    c. Information about the participant's rights to request a hearing, and

    d. An explanation of the circumstances under which Medicaid services will continue if a hearing is requested.

3. A copy of the written plan of care includes information on the appeal rights and the steps to appeal an adverse decision. A copy of this information is left in the client's home.

B. INFORMAL CONFERENCE

The client has ten (10) days from the effective date of action to request an informal conference. The client may notify the AMA in writing giving the reason for the dissatisfaction and ask for either an informal conference or a review of the case by the AMA. At the informal conference, the client may present the information and/or may be represented by a friend, relative, attorney, or other spokesperson of their choice. Services

cannot be continued pending the results of an informal conference, unless a fair hearing is also requested within 10 days of the effective date of the action.

C. REQUEST A FAIR HEARING

1. If the client is still dissatisfied after the above procedure has been completed, a fair hearing may be requested. A written request for a hearing must be filed within sixty (60) days following the action with which he or she is dissatisfied. The client or legally appointed representative or other authorized person must request the hearing and give a correct mailing address to receive future correspondence. If the request for the hearing is made by someone other than the person who wishes to appeal, the person requesting the hearing must make a definite statement that he or she has been authorized to do so by the person for whom the hearing is being requested. Information about the hearings will be forwarded and a hearing date and place convenient to the person will be arranged.

   If a client wishes to continue services while awaiting the fair hearing results, the written request for a fair hearing must be received within 10 days of the original effective date of action. If the action taken concerns a critical health and safety issue, continuation of services may not be allowed.

2. If the person is satisfied before the hearing and wants to withdraw the request, the client or legally appointed representative or other authorized person should write the AMA that he or she wishes to do so and give the reason for the withdrawal.

D. COMPLAINTS AND GRIEVANCES

1. ADPH and ADSS are responsible for explaining the procedures to clients of filing complaints and grievances. ADPH and ADSS must also have procedures in place that will assure AMA that DSP have explained to clients the process on how to register a complaint. The DSP supervisor will investigate any complaints registered by a client against any DSP workers. Any action taken will be documented in the client's record. If the client is dissatisfied with the action taken by the provider they should forward their complaint to appropriate agency and/or AMA.

   a. Complaints are submitted to ADPH, ADSS, or the AMA and are investigated through resolution. A tracking log will be used to document the incidents and resolutions of the incident in the Waiver QA Unit at AMA. The OA will also maintain a log of complaints and grievances received.

   b. If complaints are received by the AMA, a copy will be forwarded to ADPH or ADSS within two (2) working days. A summary and plan of correction will be sent from the OA to the AMA Waiver QA unit for all complaints reported within 30 days of the request for the summary or plan of correction from the AMA. The providers must forward their plan of correction to the OA who will in turn forward to AMA. The AMA will evaluate the plan of

correction within seven (7) days of receipt. If the plan of correction is not responsive to the complaint, it will be returned to the OA within two (2) days. The revised plan of correction will be resubmitted to the AMA within two (2) working days. If the summary or plan of correction carried out is found not to be responsive, the OA will have up to seven (7) days to revise the plan and carry out the appropriate action.

c. If complaints are received by ADPH or ADSS, a copy will be forwarded to the AMA within two (2) working days, if the client's health and safety are at risk. Otherwise, the complaint/grievance should be entered onto the log that is submitted to the AMA quarterly. ADPH or ADSS must investigate all complaints upon receipt of notification. Appropriate parties must initiate action within 24 hours if it appears that a client's health and safety is at risk. If necessary the complainant will be interviewed.

d. A summary and plan of correction will be sent from the provider to the OA for all complaints reported within 30 days of the request for the summary or plan of correction from the OA. The providers must forward their plan of corrections to the OA who will in turn forward to AMA. The OA will evaluate the plan of correction within seven (7) days of receipt. If the plan of correction is not responsive to the complaint, it will be returned to the provider within two (2) days. The revised plan of correction will be resubmitted to the OA within two (2) working days. If the summary or plan of correction carried out is found not to be responsive, the provider will have up to seven (7) days to revise the plan and carry out the appropriate action.

e. ADPH or ADSS will review all complaints and grievances to determine a pattern of problems in order to assure that no health and safety risks exist.

f. Final determinations including any adverse findings will be reported to the AMA.

g. The AMA will contact the client via telephone to ensure full resolution to the incident has been completed satisfactorily.

h. ADPH or ADSS will forward all grievance logs to AMA Waiver QA Unit quarterly for review, tracking, and assurance that resolutions have been completed.

CHAPTER 7

COVERED SERVICES

A. HOME AND COMMUNITY-BASED WAIVER SERVICES

The purpose of home and community-based waiver services is to provide realistic options for clients who need help to remain at home and avoid unnecessary or premature admission to a nursing home.

Home and community-based waiver services are provided by direct service providers who are contracted and enrolled as Medicaid providers to render services to eligible clients. These services are:

- Case Management T1016 UA
- Personal Care T1019 UA
- Adult Day Health S5102 UA
- Respite Care (Skilled) T1005 UA
- Respite Care (Unskilled) S5150 UA
- Homemaker S5130 UA
- Companion S5135 UA
- Home Delivered Meals (Frozen) S5170 UA
- Home Delivered Meals (Shelf Stable) S5170 SC
- Home Delivered Meals (Breakfast) S5170

A description of each covered service is included in this chapter and is part of the contractual agreement, which defines both providers' and OA's responsibilities in the provision of waiver services.

Waiver services should be authorized only when other formal community resources are not available to meet the client's needs. For example, if a volunteer meals program is available in the community, a referral should be made to access this resource.

An agency's maintenance of effort is vital in assuring that home and community-based waiver services are cost-effective programs. Maintenance of effort means that an agency will continue to provide services that the agency has in place once EDW services have been implemented. It is important that state agencies, their affiliates, and other local organizations make every effort to maintain existing services to long term care clients and to provide additional services when appropriate in order to satisfy the maintenance of effort requirement.

If an agency discontinues a service, the case manager should contact that agency to determine if it is a temporary or permanent interruption and then document the findings in the narrative accordingly.

Moreover, a client's family and/or caregiver should continue their efforts in caring for that person. In most situations, home and community-based waiver services should not replace the informal caregivers' support, but should supplement their efforts.

In summary, waiver services should only be authorized to meet the client's needs as specified in the Plan of Care and must be based on the availability of other non-Medicaid Services.

B. CHOICE OF WAIVER SERVICE PROVIDERS

1. A client, responsible party, and/or significant other must make a choice of providers for each waiver service that he or she desires. The initial choice is documented in the narrative, during the assessment visit. The case manager should supply a list to the client, responsible party, and/or significant other of all providers listed in alphabetical order for all waiver services available in the area. These waiver services should be discussed with the client, responsible party, and/or significant other during the case manager's initial visit. At the initial assessment visit, a written choice should be made for each waiver service that the client desires to access. Subsequent changes or additions of providers are made verbally and documented in the narrative. It is important that the client, responsible party, and/or significant other make this decision independently, and the case manager is cautioned not to influence a client's choice of providers.

2. If a client is not physically or mentally able to complete and/or sign a choice of provider form, the responsible party or significant other may do so for the client. The lack of a signature on the form will not preclude the client from receiving waiver services.

3. The client, responsible party, and/or significant other will be encouraged to choose at least three providers. If more than two providers are available for the chosen service, the client must prioritize the choices by numbering them "1", "2", and "3".

4. It is the responsibility of each OA to keep an updated list of providers for each waiver service available in the geographical area. A copy of this list is given to each client, responsible party, and/or significant other at each redetermination visit, so the client will always be informed of providers serving his or her area.

5. If at any time the client, responsible party, and/or significant other request an additional waiver service or a change in providers, the case manager will inform the client, responsible party, and/or significant other of all available providers of the service(s) in question. The case manager must document this information exchange as well as the client's choice of provider(s).

6. Special needs of the client, such as weekend service or specific hours of the day or evening, should be reflected on the Service Authorization Form and documented in the narrative. These needs should be presented to the chosen provider, giving that provider the opportunity to accept or reject the referral.

7. Because the condition of the client is the primary consideration and the timely initiation of services is paramount, the case manager will have the option of referring to the next provider (as prioritized by the client, responsible party, and/or significant other) if an affirmative response has not been received from the chosen provider within three (3) working days. The same will hold true if the chosen provider does not respond to a "call-back" message. When this occurs, dates and

persons contacted and other pertinent information must be documented in the narrative.

C. CONTRACTING FOR WAIVER SERVICES

1. Prior to contracting for any waiver services, the case manager must be familiar with all services. Waiver services are based on a client's need as documented in the plan of care. The plan of care should be a clear, factual representation of the client's need and support the rationale and appropriateness for a service authorization.

2. Prior to initiating a service authorization, the case manager must contact the provider to determine the start date and discuss any special needs to the client. Identification is required of the client whose needs are such that the absence of an authorized waiver service would have a substantial impact on the client's health and safety. In cases where the client is determined to be at risk for missed visits, the authorization will be flagged when initiated. If the at-risk status changes, the existing authorization is revised and sent to the provider indicating the current status.

   a. "Client-at-risk" - A client whose special needs and/or support situations are such that the absence of an authorized waiver service would have a substantial impact on the client's health and safety and there are not other reliable support systems to perform this duty. (Example: Client who is bedbound and relies on a PCW to get him/her out of bed in the morning and there are no other reliable support systems to perform this duty).

   b. Missed visits for clients at risk

      Once the client is identified as being at-risk for a missed visit the information is entered on the Service Authorization Form. The service authorization form must be flagged alerting the provider that the client has special needs.

   c. Emergency/disaster priority

      The emergency/disaster priority status is entered on the Service Authorization Form according to the description below and service planning is required in an attempt to meet the needs of a client who would be vulnerable during the emergency/disaster:

      (1) **Not Priority** - Client is not vulnerable during emergency/disaster or has adequate supports to meet his or her needs. (Example: Client with functional deficits, but family willing and able to evacuate and/or meet needs.)

(2) **Priority, Client Lives Alone** - Client lives alone and is vulnerable in emergency/disaster due to limitation of support system. (Example: Client lives alone and has no one available to evacuate him or her or has no one to give insulin.)

(3) **Priority, Advanced Medical Need** - Client has advanced medical needs and would be vulnerable during an emergency/disaster. (Example: Client is on ventilator, dialysis, or other specialized equipment/service.)

3. The Service Authorization Form must be specific and accurate, including the appropriate service. It must also include the number of units per day and days of the week (e.g. "2 units 3 x week - MWF"). The hours of service should appear on the form only if the hours indicate specific times which are essential to meeting the clients' service needs. Unless specific hours are absolutely essential, rejection of a provider due to inability to provide requested hours is neither appropriate nor allowable. The provider must, however, be given the opportunity to accept or reject the hours. The case manager must ascertain that such specific hours requested are required and not simply desired by the client. Desired hours may, of course, be negotiated with the client and with the provider during the provider's initial contact.

4. Case managers must contact the client, responsible party, and/or significant other within ten (10) working days after the service authorization start date to ensure services are implemented and to review client/agency responsibilities. This contact may be made either by telephone, home visit, or in written form. Follow-up contact with the provider(s) may be necessary to resolve questions or problems with contracted services. Regular contact must be maintained with the providers of waiver services.

D. CHANGES IN SERVICES WITHIN A CONTRACTED PERIOD

1. A permanent or temporary change in contracted services necessitates a revision on the Service Authorization Form. The type of change, permanent or temporary, must be indicated on the plan of care and documented clearly in the narrative.

2. A temporary change (increase in the number of units or change in authorized days) can be made for a period of 30 calendar days. Any change exceeding the 30 calendar days must be considered permanent for the purposes of the service authorization. A verbal approval to providers may be given for a temporary change in the number of units or days. This change must be followed by completion of a revised Service Authorization Form, which should be sent to the provider. Temporary changes should be noted on the form as a temporary change denoting the start and end dates. The services will then revert back to the authorized service schedule as indicated on the latest service authorization form.

3. New waiver service(s) may be added at any time, according to the client's need as long as the service or combination of services does not show the client needs 24-hour care. It must be documented in the narrative the reason why these changes are necessary.

E. REEVALUATION OF NECESSITY OF WAIVER SERVICES

Reevaluation of a waiver service occurs annually or any time that a reevaluation is necessary to assess the need for waiver services. At this time, the case manager must make an informed decision regarding the continuation and/or revision of waiver services.

1. Interruption of waiver services may occur for one of the following reasons:

   a. Client enters the hospital or institution (i.e., rehabilitation center, MR/MH facility) for a temporary stay; or

   b. Client is in the community but chooses not to receive services temporarily (Example: client has a doctor appointment, client goes out of town, client declines substitute worker).

2. The effective date of the interruption is the first date the service was not provided. Services must be interrupted retroactively regardless of when the OA is notified of the need for interruption.

3. Interruptions of waiver services are reported to the case manager by the service provider on a weekly basis with the Missed Visit and Service Interruption Report. The case manager must document in the narrative when the client is hospitalized or institutionalized; narration of other interruptions in service reported by the provider is mandatory.

4. The service authorization remains open when the services are interrupted. However, the case manager may choose to terminate waiver services if the services are to be interrupted for an extended time. (Example: Client goes on a planned, out-of-state visit that is scheduled to last more than 60 days.) However, the case manager may decide that a formal notification to the client, responsible party, and/or significant other is beneficial in some cases.

5. Interruption in service reported by the client, responsible party, and/or significant other (excluding calls received from providers) must be documented explaining the reason for interruption in services. This includes phone calls received from the client, responsible party, and/or significant other, as well as information obtained by the case manager during the monitoring process. The Internal Missed Visit Report Form serves as documentation of the internal missed visits reporting.

SCOPE OF SERVICE
FOR
CASE MANAGEMENT SERVICE
ELDERLY/DISABLED WAIVER

A. Definition

Case Management is an activity which assists individuals in gaining access to appropriate, needed, and desired waiver and other State Plan services, as well as needed medical, social, educational, and other appropriate services, regardless of the funding

source for the services to which access is gained. Case Management Service may be used to locate, coordinate, and monitor necessary and appropriate services.

Case Management Service may also serve to provide necessary coordination with providers of non-medical, non-waiver services when the services provided by these entities are needed to enable the individual to function at the highest attainable level or to benefit from programs for which he or she might be eligible.

Case Managers are responsible for ongoing monitoring of the provision of waiver and non-waiver services included in the individual's Plan of Care. Case Management is a waiver service available to all Elderly and Disabled (E/D) Waiver clients.

B. Objective

The objective of Case Management is to assist clients to make decisions regarding long term care. It also ensures continued access to waiver and non-waiver services that are appropriate, available, and desired by the client.

C. Description of Service to be Provided

The unit of service will be 15 minutes beginning on the date that the client is determined to be eligible for E/D Waiver Services and is entered into the Medicaid Long Term Care System. Case Management Service provided prior to waiver approval should be considered administrative. At least one face to face visit is required monthly in addition to any other Case Management activities.

1. Within the context of home and community-based services, Case Management Service may include, but is not limited to, the following functions:

    a. Conducting assessments of need and necessity for waiver services;

    b. Completing and processing level of care applications for admission, readmission, or redetermination of eligibility;

    c. Developing, monitoring, and revising the client's Care Plan in coordination with the client/caregiver;

    d. Arranging and authorizing waiver services according to the client's Care Plan;

    e. Making referrals and assisting clients to gain access to needed Medicaid State Plan and other non-waiver services;

    f. Coordinating the delivery of waiver and non-waiver services included in the client's Plan of Care;

g. Monitoring the quality and effectiveness of waiver and non-waiver services provided to the client;

h. Making at a minimum, a monthly face-to-face visit with every active waiver client to monitor the Plan of Care;

i. Monitoring the cost effectiveness of waiver services for an individual;

j. Processing transfers from county-to-county or from Operating Agency to Operating Agency;

k. Facilitating transfers to or from other home and community-based waiver programs or other types of long term care;

l. Reinstating E/D Waiver Services following a client's short-term nursing home stay;

m. Processing terminations of waiver eligibility and services;

n. Establishing and maintaining case records.

2. Prior to waiver approval, all potential clients are screened by the Case Manager to assess their possible eligibility and to determine their desire for waiver participation. The intake screening activities and eligibility determination are distinct from Direct Case Management but are included in this scope of service since they are preliminary activities necessary for waiver enrollment. Case Management provided to a client prior to waiver approval is considered administrative.

   Medicaid will not reimburse for activities performed which are not within the scope of service.

D. Staffing

1. Routine, ongoing, Case Management Service will be conducted by Case Managers who meet minimum qualifications below:

   a. Professionals having earned a Bachelor of Arts or a Bachelor of Science degree, preferably in a human services related field, from an accredited college or university, or having earned a degree from an accredited School of Social Work; or,

   b. A Registered Nurse with current licensure;

   c. Have references which will be verified and documented in the personnel file. References must include statewide criminal background checks (including sex offender registry), previous employers, and the Nurse Aide Registry(if applicable), and,

   d. Training in Case Management curriculum approved by the Alabama Medicaid Agency and the Case Management service provider.

2. All Case Managers will be required to attend a Case Managers' Orientation Program provided by the Operating Agency and approved by the Alabama Medicaid Agency and attend on-going training and in-service programs deemed appropriate.

   a. Initial orientation and training must be completed within the first three (3) months of employment as a Case Manager. Any exception to this requirement must be approved by the Alabama Medicaid Agency. Proof of the training must be recorded in the Case Manager's personnel file.

   b. The Operating Agency will be responsible for providing a minimum of six (6) hours relevant in-service training per calendar year for Case Managers. This annual in-service training requirement may be provided during one training session or may be distributed (prorated) throughout the year based on the date of employment. Proof of training must be recorded in the personnel file. Documentation shall include topic, name and title of trainer, training objectives, outline of content, length of training, list of trainees, location and outcome of training.

      In-service training for case managers should include worker safety, and infection control training and updates as necessary.

3. The Operating Agency shall maintain records on each Case Manager, which shall include the following:

   a. Application for employment and verification of educational and licensing

requirements;

b. Statewide criminal background checks;

c. References which are verified thoroughly by the DSP and documented in the personnel file;

d. Job description;

e. Record of health (annual tuberculin tests);

f. Record of pre-employment and annual in-service training;

g. Orientation;

h. Evaluations;

i. Supervision or peer review;

j. Copy of photo identification;

k. Records of all complaints/incidents lodged by the client/family/responsible party and action taken;

l. Reference contacts;

m. Documentation of quality assurance reviews.

4. The Operating Agency must have a Quality Assurance Program for Case Management Service in place and approved by the Alabama Medicaid Agency. The Quality Assurance Program shall include Case Manager record reviews at a minimum of every other month. Documentation of quality assurance reviews and corrective action must be maintained by the Operating Agency and will be subject to review by the Alabama Medicaid Agency.

E. Procedure for Service

1. Administrative Case Management

a. Intake and Screening

(1) Procedures for processing referrals to the E/D Waiver program and case assignment will be determined by the Operating Agency. Client freedom of choice options regarding Case Management Service shall be honored. All enrolled waiver clients are allowed

to choose case management providers and available Case Managers.

b. Level of Care Determination

(1) Following referral, intake and temporary case assignment, the Case Manager makes a face-to-face visit with the client for evaluation and completion of the HCBS application. To clarify the assessment information, the Case Manager may consult with the client and/or family, and physician, with regard to medical, behavioral, functional and social information.

(2) Once the Case Manager feels that he or she has adequate information for a level of care determination, an initial Plan of Care is completed. The HCBS application is reviewed by a Registered Nurse at the Operating Agency's state office for appropriateness of waiver admission. Justification for level of care determination must be properly documented in the client's file.

c. Eligibility Determination

(1) Establishing and verifying a client's financial eligibility is an important function of the Case Manager. If a client is seeking waiver services, but is not currently SSI eligible and it appears that he or she may qualify for SSI, he or she should be referred to the local social security office. If a client is not SSI eligible due to income from parent(s) or spouse, a financial application (Form 204/205) must be processed to establish financial eligibility. The Case Manager should always inform the client/family of the application process. Medicaid (financial and Long Term Care) eligibility must be verified monthly.

d. Choice of Institution or Community Care

(1) Under the provision of the E/D Waiver, applicants for waiver services or a designated responsible party will, when the applicant is found eligible for waiver services, be offered the alternative of home and community-based services or institutional services.

2. Direct Case Management

a. Plan of Care Development

(1) The Plan of Care encompasses a comprehensive review of the client's problems and strengths. Based on identified needs,

mutually agreed upon goals are set. The Plan of Care development should include participation by the client and/or family/primary caregiver, and Case Manager. The Plan of Care development process provides involved persons with information necessary to make an informed choice regarding the location of care and services to be utilized.

All waiver and non-waiver services provided to meet a client's needs should be included in the Plan of Care.

b. Initial Authorization of Waiver Services

The Case Manager will submit a written Service Authorization Form to the DSP Agency authorizing waiver service(s) and designating the units, frequency, beginning and ending dates of service, and types of duties in accordance with the individual client's needs as set forth in the Plan of Care.

c. Service Coordination

(1) To coordinate the provision of a direct E/D Waiver service to be delivered at the client's place of residence, an initial visit should be held at the client's place of residence and should include at a minimum the Case Manager, the DSP Supervisor, the client and caregiver as applicable. It is advisable to also include the DSP Worker in the initial visit.

(2) An initial visit is required when a DSP begins to provide services to a client in the client's place of residence.

(3) If a client receives more than one direct service from a DSP, only one initial visit is required. If a client has more than one DSP, an initial visit should be conducted with each DSP.

d. Monitoring

(1) Each case will be monitored monthly through contacts and at least one face-to-face visit with the client. Special emphasis will be put on discussion of the client's current health/impairment status, appropriateness of the Plan of Care, and verification that all formal and informal providers included on the Plan of Care are delivering the amount and type of services that were committed.

(2) The amount, frequency and beginning date of service depend on the client's needs.

(3) Some cases may require monitoring more frequently than monthly. Contacts for these cases will be scheduled by prioritizing clients according to medical conditions that are unstable, clients who require extensive care, and/or clients who have limited support systems.

(4) Clients and/or responsible relatives shall be instructed to notify the Case Manager if services are not provided as planned, or if the client's condition changes. However, it is the responsibility of the Case Manager to promptly identify and implement needed changes in the Plan of Care. Providers will be contacted, as necessary, to discuss the appropriate amount of service to be delivered. The Plan of Care and service authorizations will be updated to reflect any changes in service needs.

e. Changes In Services Within Authorization Period

(1) Services may be initiated or changed at any time within an authorization period to accommodate a client's changing needs. Any change in Waiver Services necessitates a revision of the Plan of Care. The revised Plan of Care must coincide with the narrative explaining the change and a new Service Authorization Form should be submitted by the Case Manager to DSP.

(2) If the DSP identifies additional duties that would be beneficial to the client's care, but are not specified on the Plan of Care, the DSP will contact the Case Manager to discuss having these duties added.

(a) The Case Manager will review the DSP's request to modify services and respond within one (1) working day of the request.

(b) The Case Manager will approve any modification of duties to be performed by the Waiver Service Worker and re-issue the Service Authorization Form accordingly.

(c) Documentation of any change in a Plan of Care will be maintained in the client's file.

(i) If the total number of hours of service is changed, a new Service Authorization Form is required from the Case Manager.

(ii) If the types or times of services are changed, a new Service Authorization Form is required from the Case Manager.

(iii) If an individual declines waiver services or has become ineligible for services, a Service Authorization Form indicating termination is required from the Case Manager.

(iv) A new Service Authorization is required following each redetermination of eligibility, even if there are no changes to the authorized services.

f. Missed Visits and Attempted Visits

The Direct Service Provider will report missed and attempted visits to the Case Manager on Monday of each week. The DSP will notify the Case Manager promptly whenever two (2) attempted visits occur in the same week. Missed or attempted visits with clients who are at-risk will be reported to the Case Manager immediately. The Case Manager should use this information to evaluate the effectiveness of the Plan of Care and to monitor client satisfaction.

g. Re-determination

(1) A complete review of every case will be done at least annually. The review shall include completion of the same HCBS application used in the initial assessment. The client's choice of location to receive long term care and Medicaid eligibility will be verified.

h. Termination of Waiver Services

(1) Any time a client no longer requires a service, the service must be officially terminated. Advance notice and appeal rights regarding the reduction, suspension or termination of a waiver service must be granted to the client. Waiver Services may be terminated at any time during an authorization period. Termination of a service will necessitate a revision of the Plan of Care. A Service Authorization Form indicating the service is terminated must be forwarded to each DSP.

i. Case Termination and Transfer

(1) When an applicant or a current waiver client relocates to another county or Operating Agency, the case is transferred to the receiving Case Manager. The sending Case Manager prepares all

necessary materials and makes initial contact with the receiving Case Manager. The receiving Case Manager is responsible for coordinating the continuation of the client's waiver services.

(2) Termination involves all activities associated with closing a waiver case when a client exits the program for specified reasons. When a client is to be terminated from the waiver, all service providers should be notified of the client's discharge immediately. At the point of termination, the Case Manager should assist as much as possible in making alternative arrangements in meeting the client's needs.

j. Documentation and Record-Keeping

(1) Adequate documentation is one of the most important tools in determining the success of the waiver program. It is vital to maintain documentation on all aspects of the waiver: from the initial data gathering process, delivery of services, complaints and grievances from recipients and providers, billing and payment records, levels of care, plans of care, Case Management narrative and cost effectiveness data. This information is used to assure that the State is operating the waiver in accordance with the approved waiver document and that waiver services are appropriate for the individuals being served.

(2) The Operating Agency shall comply with federal and state confidentiality laws and regulations in regard to client and employee files.

(3) All records regarding the provision and supervision of Case Management must be maintained in a secure, accessible location for five (5) years after services are terminated.

F. Rights, Responsibilities, and Service Complaints

1. The Operating Agency has the responsibility of informing the client of all rights and responsibilities and the manner in which service complaints may be registered.

2. The Operating Agency will ensure that the client/responsible party is informed of their right to lodge a complaint about the quality of waiver services provided and will provide information about how to register a complaint with the Case Manager as well as the Alabama Medicaid Agency.

a. Complaints which are made against a Case Manager will be investigated by the Operating Agency and documented in the client's file.

b. The Case Manager Supervisor will contact the Case Manager by letter or telephone about any complaint against the Case Manager and any recommended corrective action.

c. The Case Manager Supervisor will take the necessary action and document the action taken in the client's and employee's files.

d. All other complaints to be investigated will be referred to the Case Manager who will take appropriate action.

3. The Operating Agency must maintain documentation of all complaints, follow-up, and corrective action regarding the investigation of those complaints and documentation showing that they have complied with the requirements of this section.

G. Administrative Requirements

In addition to all conditions and requirements contained in the Scope of Service as well as in the contract, the Operating Agency shall be required to adhere to the following stipulations:

1. The Operating Agency will designate an individual to serve as the waiver coordinator who will employ qualified personnel and ensure adequate staff education, in-services training and perform employee evaluations. This does not have to be a full time position; however, the designated waiver coordinator must have the authority and responsibility for the direction of the Operating Agency. The Operating Agency shall notify in writing the Alabama Medicaid Agency within three (3) working days of a change in the waiver coordinator, address, phone number or an extended absence of the waiver coordinator.

2. The Operating Agency will maintain an organizational chart indicating the lines of authority and responsibility and make it available to the Alabama Medicaid Agency upon request.

3. Administrative and supervisory functions shall not be delegated to another agency or organization.

4. The Operating Agency will maintain a Policy and Procedures Manual to describe how activities will be performed in accordance with the terms of the contract and the Waiver Document. The Policy and Procedure Manual should include the organization's Emergency Plan regarding service delivery. All policies and procedures must be approved by the Alabama Medicaid Agency.

SCOPE OF SERVICE
FOR
PERSONAL CARE SERVICE
ELDERLY/DISABLED WAIVER

A. Definition

Personal Care Service provides assistance with eating, bathing, dressing, caring for personal hygiene, toileting, transferring from bed to chair, ambulation, maintaining continence and other activities of daily living (ADLs). It may include assistance with independent activities of daily living (IADLs) such as meal preparation, using the telephone, and household chores such as, laundry, bed-making, dusting and vacuuming, which are incidental to the assistance provided with ADLs or essential to the health and welfare of the client rather than the client's family.

Personal Care Service is not an entitlement. It is based on the needs of the individual client as reflected in the Plan of Care.

B. Objective

The objective of the Personal Care (PC) Service is to restore, maintain, and promote thehealth status of clients through home support, health observation, and support of and assistance with activities of daily living.

Personal Care Service is to help waiver clients perform everyday activities when they have a physical, mental, or cognitive impairment that prevents them from carrying out those activities independently.

C. <u>Description of Service to be Provided</u>

1. The unit of service will be 15 minutes of direct PC Service provided in the client’s residence. The number of units authorized per visit must be stipulated on the Plan of Care and the Service Authorization Form. The amount of time authorized does not include transportation time to and from the client’s residence or the Personal Care Worker's break or mealtime.

   The number of units and service provided to each client is dependent upon the individual client’s needs as set forth in the client’s Plan of Care established by the case manager.

   Medicaid will not reimburse for activities performed which are not within the scope of service.

2. PC Service duties include:

a. Support for activities of daily living, such as,

- bathing
    - personal grooming
    - personal hygiene
    - meal preparation
    - assisting clients in and out of bed
    - assisting with ambulation
    - toileting and/or activities to maintain continence

b. Home support that is essential to the health and welfare of the recipient, such as,

- cleaning
- laundry
- home safety

Home safety includes a general awareness of the home's surroundings to ensure that the client is residing in a safe environment. Any concerns with safety issues will be reported to the PCW Supervisor as well as the case manager for follow-up.

c. Reporting observed changes in the client's physical, mental or emotional condition.

d. Reminding clients to take medication.

Note: Under no circumstances should any type of skilled medical or nursing service be performed by the PCW.

D. Staffing

The DSP must provide all of the following staff positions through employment or sub contractual arrangements.

PC Supervisors and PC Workers must be qualified, trained, and employed by a Medicare/Medicaid certified Home Health Agency or other health care agencies approved by the Commissioner of the Alabama Medicaid Agency.

1. Personal Care (P/C) Supervisors must be a licensed nurse(s) who meet the following requirements:

a. Have references which will be verified thoroughly and documented in the Direct Service Provider personnel file. References must include statewide

criminal background checks, previous employers and the Nurse Aide Registry.

b. Be a Registered Nurse (RN) or Licensed Practical Nurse (LPN) who is currently licensed by the Alabama State Board of Nursing to practice nursing.

c. Have at least two (2) years experience as an RN or LPN.

d. Have the ability to evaluate the Personal Care Worker (PC Worker) in terms of his/her ability to carry out assigned duties and to relate to the client.

e. Have the ability to coordinate or provide orientation and in-service training to PC Workers on either an individual basis or in a group setting.

f. Have the ability to provide appropriate follow-up regarding a client/caregiver and/or case manager's dissatisfaction, complaints or grievances regarding the provision of PC Service.

g. Submit to a program for the testing, prevention, and control of Tuberculosis annually.

h. Possess a valid, picture identification.

2. PCWs must meet the following qualifications:

a. Have references which will be verified thoroughly and documented in the Direct Service Provider personnel file. References must include statewide background checks, previous employers, sex offender registry, and the Nurse Aide Registry (if applicable).

b. Be able to read and write.

c. Possess a valid, picture identification.

d. Be able to follow the Plan of Care with minimal supervision.

e. Assist client appropriately with activities of daily living as related to personal care.

f. Complete a probationary period determined by the employer with continued employment contingent on completion of a Personal Care in-service training program.

g. Must submit to a program for the testing, prevention, and control of tuberculosis annually.

3. Minimum Training Requirements for Personal Care Workers:

The Personal Care training program should stress the physical, emotional and developmental needs of the population served, including the need for respect of the client, his/her privacy, and his/her property. The minimum training requirement must be completed prior to initiation of service with a client. The DSP is responsible for providing/or conducting the training. The Personal Care training program must be approved by the Operating Agency. Proof of the training must be recorded in the personnel file.

Individual records will be maintained on each PCW to document that each member of the staff has met the requirements below.

Minimum training requirements must include the following areas:

a. Activities of daily living, such as,

- bathing (sponge, tub)
- personal grooming
- personal hygiene
- meal preparation
- proper transfer technique (assisting clients in and out of bed)
- assistance with ambulation
- toileting
- feeding the client

b. Home support, such as,

- cleaning
- laundry
- home safety

c. Recognizing and reporting observations of the client, such as,

- physical condition
- mental condition

- emotional condition
- prompting the client of medication regimen

d. Record keeping, such as,

- A service log signed by the client or family member/responsible person and PCW to document what services were provided for the client in relation to the Plan of Care.

- Submitting a written summary to the PCW Supervisor of any problems with client, client's home or family. The Supervisor in return should notify the case manager.

e. Communication skills

f. Basic infection control/Universal Standards

g. First aid emergency situations

h. Fire and safety measures

i. Client rights and responsibilities

j. Other areas of training as appropriate or as mandated by the Operating Agency.

4. The DSP will be responsible for providing a minimum of twelve (12) hours of relevant in-service training per calendar year for each PC Worker. In-service training is in addition to PC Worker orientation training. For PC Workers hired during the calendar year, this in-service requirement may be prorated based on date of employment as a PC Worker.

5. Documentation of the training provided shall include topic, date, name and title of trainer, objective of the training, outline of content, length of training, list of trainees and location.

6. Topics for specific in-service training may be mandated by the Operating Agency.

7. In-service training may entail demonstration of providing care to the client. Additional training may be provided as deemed necessary by the DSP. Any self-study training programs are limited to four (4) hours annually and must be approved for content and credit hours by the Operating Agency, prior to the planned training. The DSP shall submit proposed program(s) to the Operating Agency at least forty-five (45) days prior to the planned implementation.

8. The DSP must have an ongoing infection control program in effect and training on Universal Standards and an update on infection control shall be included as part of the 12 hours required in-service for all PC Workers each calendar year.

9. The DSP Agency shall maintain records on each employee, which

shall include the following:

a. Application for employment;

b. Job description;

c. Statewide criminal background checks (including sex offender registry) and references;

d. Record of health (annual tuberculin tests);

e. Record of pre-employment and in-service training;

(For PC Supervisor validation of required CEUs for licensure will be accepted.)

f. Orientation;

g. Evaluations;

h Supervisory visits;

i. Copy of photo identification;

j. Records of all complaints/incidents lodged by the client/family/responsible party and action taken;

k. Other forms as required by state and federal law, including agreements regarding confidentiality.

E. Procedures for Service

1. The case manager will submit a Service Authorization Form and Plan of Care to the DSP Agency authorizing Personal Care Service and designating the units, frequency, beginning and ending dates of service, and types of duties in accordance with the individual client's needs.

2. The DSP Agency will initiate PC Service within three (3) working days of the designated START DATE on the Service authorization form in accordance with the following:

a. Services must **not** be provided prior to the authorized start date as stated on the Service Authorization Form.

b. The DSP Agency will adhere to the services and schedule as authorized by the case manager on the Service Authorization Form. No payment will be made for services unless authorized and listed on the Plan of Care.

3. Provision of Service Authorized:

a. Personal Care Service cannot be provided at the same time other authorized waiver services are being provided except Case Management.

b. Personal Care Workers will maintain a separate service log for each client to document their delivery of services.

(1) The Personal Care Worker shall complete a service log that will reflect the types of services provided, the number of hours of service, and the date and time of the service.

(2) The service log must be signed upon each visit by the client, or family member/responsible party and the PC Worker. In the event the client is not physically able to sign and the family member/responsible party is not present to sign, then the Personal Care Worker must document the reason the log was not signed by the client or family member/responsible party.

(3) The service log will be reviewed and signed by the Personal Care Supervisor at least once every two (2) weeks. Service logs will be retained in the client's file.

(4) Client visits may be recorded electronically via telephony. Electric documentation will originate from the client's residence as indicated by the phone number at the residence. A monthly report of phone number exceptions will be maintained with written documentation giving the reason the electronic documentation did not originate at the client's residence, e.g., phone line down, client does not have phone, client staying with relatives. These electronic records may be utilized in place of client signatures.

c. Services provided by relatives or friends may be covered only if relatives or friends meet qualifications for providers of care. However, providers of service cannot be a parent/step-parent/legal guardian of a minor or a spouse of the individual receiving services, when the services are those that these persons are legally obligated to provide. There must be strict controls to ensure that payment is made to the relatives or friends as providers only in return for personal care services. Additionally, there must be adequate justification as to why the relative or friend is the

provider of care and there is documentation in the case management file showing that the family member is a qualified provider and the lack of other qualified providers in remote areas. The case manager will conduct an initial assessment of qualified providers in the area of which the client will be informed. The case manager must document in the client's file the attempts made to secure other qualified providers before a relative or friend is considered. The case manager, along with the DSPs, will review the compiled information in determining the lack of qualified providers for clients living in a remote area.

4. Monitoring of Service:

PC Service must be provided under the supervision of the registered nurse or licensed practical nurse who meets the requirements of D.1. and will:

a. Make an initial visit prior to the start of PC Service for the purpose of reviewing the plan of care, providing the client written information regarding rights and responsibilities and how to register complaints, and discussing the provisions and supervision of the service(s)."

   The initial visit should be held at the client's place of residence and should include the case manager, the PC Supervisor, the client, and the caregiver, if feasible. It is advisable to also include the PC Worker in the initial visit.

b. Be immediately accessible by phone during the time PC Service is being provided. Any deviation from this requirement must be prior approved in writing by the Operating Agency and the Alabama Medicaid Agency. If this position becomes vacant the Operating Agency and the Alabama Medicaid Agency must be notified within 24 hours when the position becomes vacant.

c. Provide and document supervision of, training for, and evaluation of PCWs according to the requirements in the approved waiver document.

d. Provide on-site (client's residence) supervision at a minimum of every 60 days for each client. Supervisory visits must be documented in the individual client record. Supervisors will conduct on-site supervision more frequently if warranted by complaints or suspicion of substandard performances by the PCW. In the event the on-site supervisory visit cannot be completed in a timely manner due to the client's being inaccessible, the supervisory visit must be completed within five (5) working days following resumption of Personal Care Service. Documentation regarding this action should be in the DSP client record. Client must be present for visit.

e. The DSP must complete the 60 day supervisory review which includes, at a minimum, assurance that the services are being delivered consistent with the Plan of Care and the Service Authorization Form in an appropriate manner, assurance that the client's needs are being met, and a brief statement regarding the client's condition. A copy of the supervisory visit must be submitted to the case manager within 10 calendar days after the 60 day supervisory review. In the event the client is not available during the time the visit would have normally been made, the review must be completed within five (5) working days of the resumption of PC Service.

f. Assist PCWs as necessary as they provide individual Personal Care Service as outlined in the Plan of Care. Any supervision/ assistance given must be documented in the individual client's record.

g. The PC Supervisor must provide direct supervision of each PC Worker with at least one (1) assigned client at a minimum of every six (6) months. Direct supervisory visits must be documented in the PC Worker's personnel record.

- Direct supervision may be carried out in conjunction with an on-site supervisory visit.
- Client and PCW have to be present

The PC Supervisor will provide and document the supervision, training, and evaluation of PC Workers according to the requirements in the approved Waiver Document.

5. Missed Visits and Attempted Visits

a. Missed Visits

(1) A missed visit occurs when the client is at home waiting for scheduled services, but the services are not delivered.

(2) The DSP shall have a written policy assuring that when a Personal Care Worker is unavailable, the Supervisor assesses the need for services and makes arrangements for a substitute to provide services as necessary/or reduced by the DSP.

Clients who are designated by the case manager as being at-risk should be given first priority when Personal Care Service visits must be temporarily prioritized and:

(a) If the Supervisor sends a substitute, the substitute will complete and sign the service log after finishing duties.

(b) If the Supervisor does not send a substitute, the Supervisor will contact the client and inform them of the unavailability of the Personal Care Worker.

(3) The DSP will document missed visits in the client's files.

(4) Whenever the DSP determines that services cannot be provided to an at-risk client as authorized, the case manager must be notified by telephone immediately. All missed/attempted visits for one week and the reason for the missed/attempted visit must be reported in writing on the **"Weekly Missed/Attempted Visit Report"** form to the case manager on Monday of each week. Any exception to the use of this form must be approved by the Operating Agency and the Alabama Medicaid Agency.

(5) The DSP may not bill for missed visits**.**

b. Attempted Visits

(1) An attempted visit occurs when the PCW arrives at the home and is unable to provide services because the client is not at home or refuses services.

(2) If an attempted visit occurs:

(a) The DSP may not bill for the attempted visits.

(b) The Supervisor will contact the client to determine the reason why the client was not present or why services were refused. Documentation of this discussion must be in the client's file.

(c) The DSP will notify the case manager promptly whenever an attempted visit occurs and will notify the case manager within one (1) working day after the second attempted visit whenever two attempted visits occur within the SAME week.

6. Changes in Services

a. The DSP will notify the case manager within one (1) working day of the following changes:

(1) Client's condition and/or circumstances have changed and the Plan of Care no longer meets the client's needs:

(2) Client does not appear to need Personal Care Service;

(3) Client dies or moves out of the service area;

(4) Client indicates Personal Care Service is not wanted;

(5) Client loses Medicaid financial eligibility;

(6) When services can no longer be provided.

b. The case manager will notify the DSP immediately if a client becomes medically or financially ineligible for waiver services.

c. If the DSP identifies additional duties that may be beneficial to the client's care, but are not specified on the Plan of Care, the DSP shall contact the case manager to discuss having these duties added.

(1) The case manager will review the DSP's request to modify services and respond within one (1) working day of the request.

(2) The case manager will approve any modification of duties to be performed by the PCW and re-issue the Service Authorization Form accordingly.

(3) Documentation of any change in a Plan of Care will be maintained in the client's file.

(a) If the total number of hours of service is changed, a new Service Authorization Form is required from the case manager.

(b) If the types or times of services are changed, a new Service Authorization Form is required from the case manager.

(c) If an individual declines PC Service or has become ineligible for services, a Service Authorization Form for termination is required from the Case Manager.

7. Documentation and Record-Keeping

a. The DSP shall maintain a record keeping system for each client that documents the units of service delivered based on the Service Authorization Form. The client's file shall be made available upon request

to Medicaid, the operating agencies, or other agencies contractually required to review information.

The DSP shall maintain a file on each client, which shall include the following:

(1) A current HCBS application;

(2) Both current and historical Service Authorization Forms specifying units, services, and schedule of Personal Care visits for the client;

(3) Documentation of client specific assistance and/or training rendered by the Supervisor to a Personal Care Worker;

(4) All service logs;

- The service log must be reviewed and initialed by the Nurse Supervisor at least once every two (2) weeks.

(5) Records of all missed or attempted visits;

(6) Records of all complaints lodged by clients or family members/responsible parties and any actions taken;

(7) Evaluations from all 60 day on-site supervisory visits to the client;

(8) The Service Authorization Form notifying the DSP Agency of termination, if applicable;

(9) Initial visit for in-home services;

(10) Any other notification to case manager;

(11) Permission statements to release confidential information, as applicable.

b. The DSP will retain a client's file for at least five (5) years after services are terminated.

c. The DSP Agency shall comply with federal and state confidentiality laws and regulations in regard to client and employee files.

F. Rights, Responsibilities, and Service Complaints

1. The Operating Agency has the responsibility of ensuring that the DSP has fulfilled its duty of properly informing the client of all rights and responsibilities and the manner in which service complaints may be registered.

2. The DSP Agency will inform the client/responsible party of their right to lodge a complaint about the quality of PC Service provided and will provide information about how to register a complaint with the case manager as well as the Alabama Medicaid Agency.

   a. Complaints which are made against PCW will be investigated by the DSP Agency and documented in the client's file.

   b. All complaints which are to be investigated will be referred to the PCW Supervisor who will take appropriate action.

   c. The PCW Supervisor will take any action necessary and document the action taken in the client's and/or the employee's files, whichever is most appropriate based on the nature of the complaint.

   d. The PCW Supervisor will contact the case manager by letter or telephone about any complaint and any corrective action taken.

3. The DSP must maintain documentation of all complaints, follow-up, and corrective action regarding the investigation of those complaints and documentation showing that they have complied with the requirements of this section.

G. Administrative Requirements

In addition to all conditions and requirements contained in the Scope of Services as well as in the contract, the DSP shall be required to adhere to the following stipulations:

1. The DSP Agency shall designate an individual to serve as the agency administrator who shall employ qualified personnel and ensure adequate staff education, in-services training and perform employee evaluations. This does not have to be a full time position; however, the designated administrator must have the authority and responsibility for the direction of the DSP Agency. The DSP Agency shall notify the Operating Agency within three (3) working days of a change in the agency administrator, address, phone number or an extended absence of the agency administrator.

2. The DSP will maintain an organizational chart indicating the administrative control and lines of authority for the delegation of responsibility down to the "hands on" client care level staff shall be set forth in writing. This information

will be readily accessible to all staff. A copy of this information shall be forwarded to the Operating Agency at the time the contract is implemented. Any future revisions or modifications shall be distributed to all staff of the DSP Agency and to the Operating Agency.

3. Administrative and supervisory functions shall not be delegated to another agency or organization.

4. A list of the members of the DSP's governing body shall be made available to the Operating Agency and/or the Alabama Medicaid Agency upon request.

5. The DSP Agency must maintain an annual operating budget which shall be made available to the Operating Agency and/or the Alabama Medicaid Agency upon request.

6. The DSP Agency shall acquire and maintain during the life of the contract liability insurance to protect all paid and volunteer staff, including board members, from liability incurred while acting on behalf of the agency. Upon request, the DSP Agency shall furnish a copy of the insurance policy to the Operating Agency and/or the Alabama Medicaid Agency.

7. The DSP Agency shall ensure that key agency staff, including the agency administrator or the DSP Supervisor, be present during compliance review audits conducted by Medicaid, the Operating Agency and/or its agents.

8. The DSP Agency shall maintain an office which is open during normal business hours and staffed with qualified personnel.

9. The Direct Service Provider (DSP) shall provide its regularly scheduled holidays to the Operating Agency. The DSP Agency must not be closed for more than four (4) consecutive days at a time and then only if a holiday falls in conjunction with a weekend. The DSP shall also provide the regular hours of business operation. If a service is needed on a scheduled holiday, the service provider will ensure that the service is rendered.

10. The DSP Agency will maintain a Policy and Procedures Manual to describe how activities will be performed in accordance with the terms of the Operating Agency contract and the Waiver Document. The Policy and Procedure Manual should include the organization's Emergency Plan regarding service delivery.

11. <u>Any</u> DSP staff, including administrative, that have any direct client contact must participate in a program for testing, prevention, and control of tuberculosis annually.

H. Provider Experience

Providers of Personal Care Service must meet all provider qualifications prior to rendering the Personal Care Service.

All personnel with direct client contact or access to client information must have complete reference verification and statewide criminal background checks on file prior to client contact or access to client information.

SCOPE OF SERVICE
FOR
ADULT DAY HEALTH SERVICE
ELDERLY/DISABLED WAIVER

A. Definition

Adult Day Health (ADH) is a service that provides Elderly and Disabled Waiver (EDW) clients with a variety of health, social, recreational, and support activities in a supervised group setting for four or more hours per day on a regular basis.

Transportation between the individual's place of residence and the adult day health center will be provided as a component part of Adult Day Health Service. The cost of this transportation is included in the rate paid to providers of Adult Day Health Service.

Adult Day Health is not an entitlement. It is based on the needs of the adult client.

B. Objective

The objective of Adult Day Health is to provide a continuing organized program of rehabilitative, therapeutic and supportive health and social services and activities to the Elderly and Disabled Waiver clients who are functionally impaired and who, due to the severity of their functional impairment, are not capable of living in the community independently.

C. Description of Adult Day Health Service to be Provided

The unit of service will be a client day of Adult Day Health Service consisting of four (4) or more hours at the center. The four (4) hour minimum for a client day does not include transportation time. The number of units authorized per visit must be stipulated on the Plan of Care and the Service Authorization Form.

Medicaid will not reimburse for services rendered by a provider that have not been approved by Medicaid's Waiver QA Program as an ADH Provider.

Medicaid will not reimburse for activities performed which are not within the scope of service.

Adult Day Health Service is provided within a maintenance model of care, which provides services that include the following health and social activities, needed to ensure optimal functioning of the client.

1. Observe the status of the individual's health that includes support in carrying out physician orders as needed; monitoring of vital signs as needed; observing the

functional level of the client and noting any changes in the physical condition of each individual; supervising medication and observing for possible reaction; teaching positive health measures and encouraging self-care; appropriately reporting to the caregiver and case manager any changes in the client's condition.

2. According to the Alabama Board of Nursing medications can be administered by a Registered Nurse (RN) or Licensed Practical Nurse (LPN) who is currently licensed by the Alabama State Board of Nursing to practice nursing. The medication must be filled by a pharmacy with physician instructions written on the label. The written instructions on the container are considered a physician order. However, the nurse has an additional obligation to keep a record of all medications given to a client in
the client's file. This policy is applicable, if a nurse is on staff at the facility. Medications cannot be administered by any other staff member at the ADH center. However, the other staff member can remind a client to take medication when necessary.

3. Observe and assist the client to maintain good personal hygiene on a daily basis.

4. Provide planned therapeutic activities on a daily basis to stimulate the client's mental and physical activity, communication and self-expression. These include reality orientation exercises, crafts, music, educational and cultural program, and games, etc.

5. Provides a variety of opportunities for group socialization.

6. Observe and assist the client with meal and eating.

7. Develop a plan to address medical emergencies, fire, and natural disaster.

8. Assist in the development of self-care, personal hygiene, and social support services.

9. Provide nourishment appropriate to the number of hours he or she attends the Adult Day Health center, but not equal to a full nutritional regime (3 meals per day). Specific diet requirements should be encouraged.

10. No other waiver service, except Case Management, may be provided during the time the client is receiving Adult Day Health Service.

Note: Under no circumstances should the unlicensed Adult Day Health Workers perform any type of skilled medical or nursing service.

D. Staffing

The DSP must provide all of the following staff positions through employment or sub-contractual arrangements.

1. Director of Adult Day Health Centers

All Adult Day Health Center Directors must meet the following requirements:

a. Have a statewide criminal background check (including sex offender registry);

b. Have references which are verified thoroughly by the DSP and documented in the personnel file. References must include previous employers and the Nurse Aide Registry (if applicable);

c. Have sufficient education (high school diploma or equivalent) and language ability to communicate effectively, understand written instructions and write basic reports;

d. Have the ability to evaluate Adult Day Health employees in terms of their ability to perform assigned duties and communicate with the clients;

e. Have the ability to assume responsibility for orientation and in-service training for Adult Day Health Workers by individual instructions, group meetings, or workshops;

f. Have the ability to provide appropriate follow-up regarding a client/caregiver and/or Case Managers dissatisfaction, complaints or grievances regarding the provision of Adult Day Health Service;

g. Submit to a program for the testing, prevention, and control of tuberculosis annually;

h. Possess a valid, picture identification.

2. Adult Day Health Workers

Staff, volunteer and paid employees must meet the following requirements:

a. Be able to follow the Plan of Care with minimal supervision;

b. Be able to read and write;

c. Submit to a program for the testing, prevention, and control of tuberculosis annually;

d. Have statewide criminal background check (including sex offender registry);

e. Have references which are verified thoroughly by the DSP and documented in the personnel file. References must include previous employers and the Nurse Aide Registry (if applicable);

f. Have a valid Alabama driver's license if transporting Adult Day Health clients;

g. Possess a valid, picture identification.

3. Training

The Adult Day Health training program should stress the physical, emotional and developmental needs of the population services, including the need for respect of the client, his/her privacy, and his/her property. The minimum training requirement must be completed prior to initiation of service with a client. The DSP is responsible for providing and/or conducting the training. The Adult Day Health training program must be approved by the Operating Agency. Proof of the training must be recorded in the Adult Day Health Worker personnel file.

Individual records will be maintained on each Adult Day Health Worker to document that each member of the staff has met the requirements below.

All Adult Day Health Workers must have at least six (6) hours in-service training annually. Training requirements must include the following areas:

a. Behavioral interventions, acceptance, and accommodation;

b. Providing care and supervision including individual safety and non-medical care;

c. First aid in emergency situations;

d. Documenting client's participation;

e. Fire and safety measures;

f. Confidentiality;

g. Client rights;

h. Needs of the elderly and disabled population;

i. Basic infection control/Universal Standards;

j. Communication skills;

k. Other areas of training as appropriate or as mandated by the Operating Agencies.

Documentation of the training provided shall include topic, name and title of trainer, objective of the training, date of the training, outline of content, length of training, list of trainees, and location.

Topics for specific in-service training may be mandated by the Operating Agency.

In-service training may entail demonstration of providing care to the client. Additional training may be provided as deemed necessary by the DSP. Any self-study training programs must be approved for content and credit hours by the Operating Agency, prior to the planned training. The DSP shall submit proposed program(s) to the Operating Agency at least 45 days prior to the planned implementation. The in-service training is in addition to the required training prior to delivery of Adult Day Health Service.

The DSP must have an ongoing infection control program in effect and training on Universal Standards and an update on infection control shall be included as part of the six (6) hours required in-service training for all Adult Day Health Workers each calendar year.

The Adult Day Health center must maintain records on each employee, which must include the following:

(1) Application for employment;

(2) Job description;

(3) Statewide criminal background check (including sex offender registry);

(4) Have references which have been verified thoroughly by the DSP and documented in the personnel file;

(5) Record of health (annual tuberculin tests);

(6) Record of pre-employment and in-service training;

(7) Orientation;

(8) Evaluations;

(9) Reference contacts;

(10) Records of all complaints/incidents lodged by the client/family and action taken;

(11) Other forms as required by state and federal law, including agreements regarding confidentiality.

4. Nursing Staff

A Registered Nurse(s) or Licensed Practical Nurse(s) who meets the following requirements:

a. Currently licensed by the Alabama State Board of Nursing.

b. At least two (2) years experience as a Registered Nurse or Licensed Practical Nurse.

c. Must submit to a program for the testing, prevention, and control of tuberculosis annually.

d. Statewide criminal background check (including sex offender registry);

e. Have references which are verified thoroughly by the DSP and documented in the personnel file. References must include previous employers and the Nurse Aide Registry (if applicable);

f. Possess a valid, picture identification.

E. Procedure of Service

1. The Case Manager will submit a Service Authorization Form and Plan of Care to the Adult Day Health center authorizing Adult Day Health Service designating the units, frequency, beginning date of service, and types of activities in accordance with the clients needs.

2. The Adult Day Health Provider will initiate Adult Day Health Service within three (3) working days of the designated START DATE on the Service Authorization Form in accordance with the following:

a. Services must not be provided prior to the authorized start date as stated on the Service Authorization Form.

b. The Adult Day Health Provider will adhere to the services and schedule as authorized by the Case Manager on the Service Authorization Form. No payment will be made for services unless authorized and listed on the Plan of Care.

c. On the first day of service the provider will review the plan of care, provide the client written information regarding rights and responsibilities and how to register complaints, and discuss the provisions and supervision of the service(s).

3. Missed Visits

a. A missed visit occurs when the client is scheduled but does not attend.

b. All client absences for the week must be reported in writing to the Case Manager on Monday of the new week.

4. Changes in Services

a. The Adult Day Health Provider will notify the Case Manager within one (1) working day of the following changes:

(1) Client's condition and/or circumstances have changed and the Plan of Care no longer meets the client's needs;

(2) Client does not appear to need Adult Day Health Service;

(3) Client dies or moves out of the service area;

(4) Client indicates Adult Day Health Service is not wanted; and,

(5) Client loses Medicaid financial eligibility;

(6) When services can no longer be provided.

b. The Case Manager will notify the DSP immediately if a client becomes medically or financially ineligible for waiver services.

c. If the DSP identifies additional duties that may be beneficial to the client's care, but are not specified on the Plan of Care, the DSP shall contact the Case Manager to discuss having these duties added.

(1) The Case Manager will review the DSP's request to modify services and respond within one (1) working day of the request.

(2) The Case Manager will approve any modification of duties to be performed by the Adult Day Health Worker and re-issue the Service Authorization Form accordingly, if he/she concurs with the request.

(3) Documentation of any change in a Plan of Care will be maintained in the client's file.

(a) If the total number of hours of service is changed, a new Service Authorization Form is required from the Case Manager.

(b) If the types or times of services are changed, a new Service Authorization Form is required from the Case Manager.

(c) If an individual declines Adult Day Health Service or has become ineligible for services, a Service Authorization Form for termination is required from the Case Manager.

5. Documentation Record-Keeping

The Adult Day Health Provider will maintain a record-keeping system, which establishes a client profile based on the Service Authorization Form.

The DSP shall maintain a file on each client, which shall include the following:

(1) A current HCBS application;

(2) Both current and historical Service Authorization Forms;

(3) Documentation of all care and services provided;

(4) Records of all complaints lodged by clients or family members/responsible parties and any action taken;

(5) All service logs;

(6) Any notification to the Case Manager;

(7) Daily attendance records must be kept in each individual client file. The attendance record should be initialed daily and signed weekly by the client. In the event the client is not able to sign and

family member or responsible party is not present to sign, the Adult Day Health center must
document on the attendance record the reason the attendance record was not signed in the client file. The attendance record must be reviewed and initialed by the Adult Day Health Center Director at least every two (2) weeks.

The Adult Day Health Provider should notify the Case Manager in writing regarding any report or indication from the Adult Day Health Worker regarding a significant change in the client's physical, mental or emotional health. The Adult Day Health Supervisor should document such action in the DSP client file.

6. The Adult Day Health Provider must submit to the Case Manager, every 60 days a brief summary of the client's condition, an evaluation of the effectiveness of the service as it relates to the Plan of Care, and suggestions relative to the client's needs. The activities the client participates in should be included in the brief summary.

7. The Adult Day Health Provider shall comply with federal and state confidentiality laws and regulations in regard to client and personnel file.

8. The Case Manager will request Adult Day Health Service by authorizing the amount, beginning dates of service, and frequency of service for clients in accordance with the client's Plan of Care which will be developed in consultation with the client.

9. The Case Manager will notify the Adult Day Health Provider immediately if a client becomes medically or financially ineligible for Adult Day Health Service.

10. The number of days a client attends each week is dependent upon the individual client's needs as set forth in the Plan of Care established by the case manager.

11. No payment will be made for services not documented on the Plan of Care and the Service Authorization Form.

12. Medicaid will not reimburse for activities performed which are not within the scope of services.

F. Conditions of Participation

1. The Adult Day Health Provider must maintain a current Adult Day Health approval issued from the Alabama Medicaid Agency. (The Alabama Medicaid Agency issues approval for only those Adult Day Health centers that participate in the Elderly and Disabled Waiver program.) Approval depends upon compliance

with the Adult Day Care Standards of this manual and the Adult Day Health Service requirements in the approved Elderly and Disabled Waiver document. The approval will be issued by the Alabama Medicaid Agency after an on-site visit by the Quality Assurance Unit. The Adult Day Health center will be issued an approval for the facility to participate in the Elderly and Disabled Waiver program for a period of no more than two (2) years if all requirements are met. Requirements for approval are as follows:

a. The Adult Day Health center must meet the standards in waiver document Appendix C-3:9;

b. The Adult Day Health center must meet the requirements in the approved waiver document;

c. Services must be delivered consistent with the Plan of Care;

d. The client's needs must be met.

There should be no deviation from these requirements.

2. The Adult Day Health Provider will incorporate in the procedures for operation of the center adequate safeguards to protect the health and safety of the clients in the event of a medical or other emergency.

3. The Adult Day Health Provider must maintain a current (within past l2 months) fire inspection.

4. The ADH provider must conduct and document (monthly) fire and or weather drills. Documentation of drills shall include date, time, duration, number of clients' participation, number of staff participating and name of staff conducting the drill.

5. The Adult Day Health Provider must maintain a current (within past l2 months) health inspection if food is prepared and an approval from the Health Department (within l2 months) if receiving catered food.

6. The Adult Day Health Provider must maintain adequate staff for the number of clients served in the center.

a. One Adult Day Health Worker plus the director for 1-10 clients.

b. Two Adult Day Health Workers plus the director for 11-25 clients.

c. Three Adult Day Health Workers plus the director for 26-35 clients.

d. Four Adult Day Health Workers plus the director for 36-43 clients.

Add one Adult Day Health Worker for each additional 8 clients.

7. The Adult Day Health Provider must have at least two staff members certified in CPR and First Aid.

8. The Adult Day Health Provider must have one person trained to act on behalf of the Adult Day Health Director in his or her absence.

9. The Adult Day Health Provider must have a registered nurse (RN) or license practical nurse (LPN) available monthly for consultation. Monthly health screens include, but are not limited to: checking vital signs, weighing clients if applicable, and monthly health and nutritional teaching.

10. Any ADH staff, including administrative, that have direct client contact must submit to a program for the testing, prevention, and control of tuberculosis annually.

G. Rights, Responsibilities, and Service Complaints

The Operating Agency has the responsibility of ensuring that the Adult Day Health Provider has fulfilled its duty of properly informing the client of all rights and responsibilities and the manner in which service complaints may be registered.

The DSP Agency will inform the client/responsible party of their right to lodge a complaint about the quality of Adult Day Health Service provided and will provide information about how to register a complaint with the Case Manager as well as the Alabama Medicaid Agency.

1. Complaints that are made against Adult Day Health Workers will be investigated by the Adult Day Health Provider and documented in the client's file.

2. All complaints that are to be investigated will be referred to the Adult Day Health Director who will take appropriate action.

3. The Adult Day Health Director will take any action necessary and document the action taken in the client and employee's files.

4. The Adult Day Health Director will contact the Case Manager by letter or telephone about any complaint and any corrective action taken.

5. The Adult Day Health Provider must maintain documentation of all complaints, follow-up, and corrective action regarding the investigation of those complaints and documentation showing that they have complied with the requirements of this section.

H. Administrative Requirements

In addition to all conditions and requirements contained elsewhere in this Scope of Services as well as in the Adult Day Care standards and the contract, the Adult Day Health Provider shall be required to adhere to the following stipulations:

1. The Adult Day Health Provider shall designate an individual to serve as the agency administrator. This does not have to be a full time position; however, the designated administrator must have the authority and responsibility for the direction of the Adult Day Health Center. The Adult Day Health Provider shall notify the Operating Agency within three (3) working days in the event of a change in the agency administrator, address, or phone number.

2. The agency will maintain an organizational chart indicating the administrative control and lines of authority for the delegation of responsibility down to the "hands-on" client care level staff shall be set forth in writing. This information shall be readily accessible to all staff and shall include an organizational chart. A copy of this information shall be forwarded to the Operating Agency at the time the contract is implemented. Any future revisions or modifications shall be distributed to all staff of the Adult Day Health Provider and to the Operating Agency.

3. The Adult Day Health Provider shall ensure that key agency staff, including the agency administrator or the DSP Supervisor, be present during compliance review audits conducted by Medicaid, the Operating Agency and/or its agents.

4. Administrative and supervisory functions shall not be delegated to another agency or organization.

5. A governing body or designated persons so functioning shall assume full legal authority for the operation of the Adult Day Health center. A list of the members of the governing body will be made available to the Operating Agency and the Alabama Medicaid Agency upon request.

6. The Adult Day Health Provider must maintain an annual operating budget, which will be made available to the Operating Agency or the Alabama Medicaid Agency upon request.

7. During the life of the contract, the Adult Day Health Provider will acquire and maintain contract liability insurance to protect all paid and volunteer staff including board members, from liability incurred while acting on behalf of the Adult Day Health Center. Upon request, the Adult Day Health Provider will furnish a copy of the insurance policy to the Operating Agency and the Alabama Medicaid Agency.

SCOPE OF SERVICE
FOR
RESPITE CARE SERVICE
ELDERLY/DISABLED WAIVER

A. Definition

Respite Care is provided to individuals unable to care for themselves and is furnished on a short-term basis because of the absence of, or need for relief of those persons normally providing the care.

Skilled or Unskilled Respite is provided for the benefit of the client and to meet client needs in the absence of the primary caregiver(s) rather than to meet the needs of others in the client's household.

Respite Care is not an entitlement. It is based on the needs of the individual client as reflected in the Plan of Care.

B. Objective

The objective of Respite Care is to provide temporary care for clients who live at home and are cared for by their families or other informal support systems. This service will provide temporary, short term relief for the primary caregiver, and continue the supervision and supportive care necessary to maintain the health and safety of waiver clients. Respite Care is intended to supplement, not replace care provided to waiver clients.

Skilled or Unskilled Respite is provided to clients who have a physical, mental, or cognitive impairment that prevents them from being left alone safely in the absence or availability of the primary caregiver.

C. Description of Service to be Provided

1. The unit of service is 15 minutes of direct Respite Care provided in the client's residence. The amount of time does not include the Respite Care Worker's (RCW) transportation time to or from the client's residence or the Respite Care Worker's break or mealtime.

2. The number of units and services provided to each client is dependent upon the individual client's need as set forth in the client's POC established by the Case Manager. In-home Respite Service may be provided for a period not to exceed 720 hours per waiver year (October 1-September 30) in accordance with the provider contracting period. This limitation applies to skilled and unskilled respite or a combination.

Medicaid will not reimburse for activities performed which are not within the scope of services defined.

3. As implied in the definition, Respite Care is for the relief of the family member or primary caregiver; therefore, there must be a primary caregiver identified for each client that uses the Respite Care Service. The primary caregiver does not have to reside in the residence; however, there must be sufficient documentation to establish that the primary caregiver to be relieved furnishes substantial care of the client.

4. This service must not be used to provide continuous care while the primary caregiver is working or attending school.

5. No payment will be made for services not documented on the Plan of Care and the Service Authorization Form.

6. The type of in-home respite (skilled or unskilled) provided to each client will be dependent upon the individual client's needs as established by the Case Manager and set forth in the client's Plan of Care.

   a. Skilled Respite:

      (1) Skilled Respite Service will provide skilled medical or nursing observation and services and will be performed by a Registered Nurse or Licensed Practical Nurse who will perform their duties in compliance with the Nurse Practice Act.

         (a) Orders from the client’s physician(s) are required annually and when any changes occur.

         (b) It is the responsibility of the Skilled Respite Provider to obtain such physician orders for the skilled nursing services needed by the client.

      (2) In addition to providing supervision to the client, Skilled Respite may include, but is not limited to, the following activities:

         (a) Assistance with activities of daily living (ADLs), such as,

            - Bathing, personal hygiene and grooming
            - Dressing
            - Toileting or activities to maintain continence
            - Preparing and serving meals or snacks and providing assistance with eating
            - Transferring

- Ambulation

(b) Home support that is essential to the health and welfare of the recipient, such as,

- Cleaning
- Laundry
- Assistance with communication
- Home safety

Home safety includes a general awareness of the home's surroundings to ensure that the client is residing in a safe environment. Any concerns with safety issues will be reported to the Case Manager for follow-up.

(c) Skilled nursing services as ordered by the client's physician, including administering medications.

(d) Skilled medical observation and monitoring of the client's physical, mental or emotional condition and the reporting of any changes.

(e) Orienting the client to daily events.

b. Unskilled Respite:

(1) Unskilled Respite Services will provide and/or assist with activities of daily living and observations. Unskilled Respite will be performed by a Personal Care worker.

(2) In addition to providing supervision to the client, Unskilled Respite may include, but is not limited to, the following activities:

a. Meal or snack preparation, meal serving, cleaning up afterwards;

b. General housekeeping includes cleaning (such as sweeping, vacuuming, mopping, dusting, taking out trash, changing bed linens, defrosting and cleaning the refrigerator, cleaning the stove or oven, cleaning bathrooms); laundry (washing clothes and linen, ironing, minor mending); and, other activities as needed to maintain the client in a safe and sanitary environment;

c. Assistance with communication which includes placing phone within client's reach and physically assisting

client with use of the phone and orientation to daily events;

d. Support for activities of daily living, such as,

- bathing
- personal grooming
- personal hygiene
- assisting clients in and out of bed
- assisting with ambulation
- toileting and/or activities to maintain continence

e. The Respite Care worker will ensure that the client is residing in a safe environment. Any concerns with safety issues will be reported to the Respite Care Worker Supervisor as well as the Case Manager for follow-up;

f. Reporting observed changes in the client's physical, mental or emotional condition;

g. Reminding clients to take medication.

Note: Under no circumstances should any type of skilled medical or nursing service be performed by an Unskilled Respite worker.

D. Staffing

The DSP must provide all of the following staff positions through employment or sub contractual arrangements.

1. Skilled Respite Supervisors must meet the following qualifications and requirements:

   a. Be a Registered Nurse (RN) who is currently licensed by the Alabama State Board of Nursing to practice nursing.

   b. Have references which will be verified thoroughly and documented in the Direct Service Provider personnel file. References must include state criminal background checks (including sex offender registry), previous employers, and the Nurse Aide Registry (if applicable).

c. Have at least two (2) years experience as a Registered Nurse in public health, hospital, home health, or long term care nursing.

d. Have the ability to evaluate the Skilled Respite Worker (SR Worker) in terms of his or her ability to carry out assigned duties and his or her ability to relate to the client.

e. Have the ability to assume responsibility for in-service training for RCWs by individual instruction, group meetings or workshops.

f. Have the ability to provide appropriate follow-up regarding a client/caregiver and/or Case Managers dissatisfaction, complaints or grievances regarding the provision of Respite Care Service.

g. Submit to a program for the testing, prevention, and control of tuberculosis annually.

h. Possess a valid, picture identification.

2. Skilled Respite Worker - A Licensed Practical Nurse (LPN) or Registered Nurse (RN) who meets the following requirements:

a. Be currently licensed by the State of Alabama to practice nursing.

b. Have at least two years experience.

c. Submit to a program for testing, prevention, and control of tuberculosis, annually.

d. Be able to follow the Plan of Care with minimal supervision unless there is a change in the client's condition.

e. Possess a valid, picture identification.

f. Have references which will be verified thoroughly and documented in the Direct Service Provider personnel file. References must include state criminal background checks (including sex offender registry), previous employers, and the Nurse Aide Registry (if applicable).

Minimum Training Requirements for Skilled Respite Care Workers (LPN or RN):

The Direct Service Provider (DSP) must assure Medicaid and the Operating Agency (OA) that the nurse has adequate experience and expertise to perform the skilled services and the care required by the client.

Provide validation of CEUs for licensure.

3. Unskilled Respite Supervisors and workers must be qualified, trained, and employed by a Medicare/Medicaid certified Home Health Agency or other health care agencies approved by the Commissioner of the Alabama Medicaid Agency.

   Unskilled Respite Supervisors must have references which will be verified thoroughly and documented in the Direct Service Provider personnel file. References must include state criminal background checks, previous employers, and the Nurse Aide Registry (if applicable).

   Unskilled Respite Worker – USR workers must meet the following qualifications and requirements:

   a. Have references which will be verified and documented in the Direct Service Provider personnel file. References must include statewide criminal background checks, previous employers, and Nurse Aide Registry (if applicable).

   b. Be able to read and write.

   c. Possess a valid, picture identification.

   d. Be able to follow the Plan of Care with minimal supervision.

   e. Assist client appropriately with activities of daily living.

   f. Complete a probationary period determined by the employer with continued employment contingent on completion of an unskilled respite care in-service training program.

   g. Must submit to a program for the testing, prevention, and control of tuberculosis annually.

4. Minimum Training Requirements for Unskilled Respite Care Worker:

   The Unskilled Respite Care training program should stress the physical, emotional and developmental needs of the population served, including the need for respect of the client, his/her privacy, and his/her property. The minimum training requirement must be completed prior to initiation of service with a client. The DSP is responsible for providing/or conducting the training. The Unskilled Respite Care training program must be approved by the Operating Agency. Proof of the training must be recorded in the personnel file.

Individual records will be maintained on each USR worker to document that each member of the staff has met the requirements below.

Minimum training requirements must include the following areas:

a. Activities of daily living, such as,

- bathing (sponge, tub)
- personal grooming
- personal hygiene
- proper transfer technique (assisting clients in and out of bed)
- assistance with ambulation
- toileting
- feeding the client

b. Home support, such as,

- maintaining a safe and clean environment,
- providing care which includes; individual safety, laundry, serve and prepare meals and
- household management

c. Recognizing and reporting observations of the client, such as,

- physical condition
- mental condition
- emotional condition
- prompting the client of medication regimen

d. Record keeping, such as,

- A service log signed by the client or family member/responsible person and USR Care worker to document what services were provided for the client in relation to the Plan of Care.

- Submitting a written summary to the USR Care Worker Supervisor of any problems with client, client's home or family. The Supervisor in return should notify the Case Manager.

e. Communication skills

f. Basic infection control/Universal Standards

g. First aid emergency situations

h. Fire and safety measures

i. Client rights and responsibilities

j. Other areas of training as appropriate or as mandated by the Operating Agency

5. The DSP will be responsible for providing a minimum of 12 hours of relevant in-service training per calendar year for each USR worker.
In-service training is in addition to USR Worker orientation training. For USR workers hired during the calendar year, this in-service requirement may be prorated based on date of employment as a USR Worker.

6. Documentation of the training provided shall include topic, date, name and title of trainer, objective of the training, outline of content, length of training, list of trainees and location.

7. Topics for specific in-service training may be mandated by the Operating Agency.

8. In-service training may entail demonstration of maintaining a safe and clean environment and providing care to the client. Additional training may be provided as deemed necessary by the DSP. Any self-study training programs are limited to four (4) hours annually and must be approved for content and credit hours by the Operating Agency, prior to the planned training. The DSP shall submit proposed program(s) to the Operating Agency least 45 days prior to the planned implementation.

9. The DSP must have an ongoing infection control program in effect and training on Universal Standards and an update on infection control shall be included as part of the 12 hours required in-service for all USR workers each calendar year.

10. The DSP Agency shall maintain records on each employee which shall include the following:

a. Application for employment;

b. Statewide criminal background checks and references

c. Job description;

d. Record of health with annual tuberculin tests for any staff member, including administrative, that has direct client contact;

e. Record of pre-employment and annual in-service training;

(1) For Skilled Respite Supervisors and Skilled Respite Workers validation of required CEUs for licensure will be accepted for in-service.

(2) For USR Supervisor validation of required CEUs for licensure will be accepted.

f. Orientation;

g. Evaluations;

h. Supervisory visits;

i. Copy of photo identification;

j. Records of all complaints/incidents lodged by the client/family/responsible party and action taken;

k. Other forms as required by state and federal law, including agreements regarding confidentiality.

E. Procedure for Service

1. The Case Manager will submit a Service Authorization Form and Plan of Care to the DSP Agency authorizing Respite Care designating the units, frequency, beginning date of service, and types of duties in accordance with the individual client's needs. This documentation will be maintained in the client's file.

2. The DSP Agency will initiate Respite Care within three (3) working days of the designated START DATE receiving the Service Authorization Form in accordance with the following:

a. Services must not be provided prior to the authorized start date as stated on the Service Authorization Form.

b. The DSP Agency will adhere to the services and schedule as authorized by the Case Manager on the Service Authorization Form.

c. No payment will be made for services unless authorized and listed on the Plan of Care.

d. The DSP will retain a client's file for at least five (5) years after services are terminated.

3. Provision of Service authorized:

a. Respite Care cannot be provided at the same time other authorized waiver services are being provided with the exception of Case Management.

b. Services provided by relatives or friends may be covered only if relatives or friends meet the qualifications as providers of care. However, providers of service cannot be a parent/step-parent/legal guardian of a minor or a spouse of the individual receiving services, when the services are those that these persons are legally obligated to provide. There must be strict controls to assure that payment is made to the relatives or friends as providers only in return for respite care services. Additionally, there must be adequate justification as to why the relative or friend is the provider of care and there is documentation in the case management file showing that the family member is a qualified provider and the lack of other qualified providers in remote areas. The case manager will conduct an initial assessment of qualified providers in the area of which the client will be informed. The case manager must document in the client's file the attempts made to secure other qualified providers before a relative or friend is considered. The case manager, along with the DSPs, will review the compiled information in determining the lack of qualified providers for client's living in a remote area.

4. Respite Care Worker will maintain a separate service log for each client to document their delivery of services.

a. The Respite Care Worker shall complete a service log that will reflect the types of services provided, the number of hours of service, and the date and time of the service.

b. The service log must be signed upon each visit by the client, or family member/responsible party. In the event the client is not physically able to sign and the family member/responsible party is not present to sign, then the Respite Care Worker must document the reason the log was not signed by the client or family member/responsible party.

c. The Skilled Respite Worker must fully document the skilled nursing services that were authorized by the client's physician and performed for the client during each visit in which Skilled Respite was provided.

d. The service logs for Unskilled Respite and the documentation forms for Skilled Respite will be reviewed and signed by the Unskilled or Skilled Respite Supervisor respectively at least once every two (2) weeks. Daily service logs and documentation forms will be retained in the client's file.

e. Client visits may be recorded electronically via telephony. Electric documentation will originate from the client's residence as indicated by the phone number at the residence. A monthly report of phone number

exceptions will be maintained with written documentation giving the reason the electronic documentation did not originate at the client's residence, e.g., phone line down, client does not have phone, client staying with relatives. These electronic records may be utilized in place of client signatures.

f. The DSP Supervisor should notify the Case Manager in writing regarding any report or indication from the DSP Worker regarding a significant change in the client's physical, mental or emotional health. The DSP Supervisor should document such action in the DSP client file.

5. Monitoring of Service:

Unskilled Respite Care must be provided under the supervision of the Registered Nurse or Licensed Practical Nurse who meets the requirements of D.1.b.-h. and will:

a. Make an initial visit to the client's residence prior to the start of Respite Care for the purpose of reviewing the Plan of Care, providing written information to the client regarding rights and responsibilities, how to register complaints, and discussing the provisions and supervision of the service(s)."

b. Be immediately accessible by phone. Any deviation from this requirement must be prior approved in writing by the Operating Agency and the Alabama Medicaid Agency. If this position becomes vacant, the Operating Agency and the Alabama Medicaid Agency must be notified within 24 hours.

c. Provide and document supervision of, training for, and evaluation of Unskilled Respite Care Workers according to the requirements in the approved waiver document.

d. Provide on-site (client's residence) supervision at a minimum of every 60 days for each client. Supervisory visits must be documented in the individual client record. Supervisors will conduct on-site supervision more frequently if warranted by complaints or suspicion of substandard performances by the Unskilled Respite Care Worker. Client must be present for visit.

e. Assist Unskilled Respite Care Workers as necessary as they provide individual Respite Service as outlined by the Plan of Care. Any supervision/assistance given must be documented in the individual client's record.

f. The Skilled Respite Supervisor will provide on-site (client's residence) supervision at a minimum of every 60 days for each client. Supervisory visits must be documented in the individual client record. Supervisors will conduct on-site supervision more frequently if warranted by complaints or suspicion of substandard performances by the Skilled Respite Care Worker. Client must be present for visit.

g. The SR and USR Supervisor must provide direct supervision of each SR and USR Worker with at least one (1) assigned client at a minimum of every six (6) months. Direct supervisory visits must be documented in the Worker's personnel record.

- Direct supervision may be carried out in conjunction with an on-site supervisory visit.
- Client and worker have to be present.

The SR and USR Supervisor will provide and document the supervision, training, and evaluation of SR and USR Workers according to the requirements in the approved Waiver Document.

6. Missed Visits and Attempted Visits

a. Missed Visits

(1) A missed visit occurs when the client is at home waiting for scheduled services, but the services are not delivered.

(2) The DSP shall have a written policy assuring that when a Respite Care Worker is unavailable, the Supervisor assesses the need for services and makes arrangements for a substitute to provide services as necessary.

(a) If the Supervisor sends a substitute, the substitute will complete and sign the service log after finishing duties.

(b) If the Supervisor does not send a substitute, the Supervisor will contact the client and inform them of the unavailability of the Respite Care Worker.

(3) The DSP will document missed visits in the client's files.

(4) Whenever the DSP determines that services cannot be provided as authorized, the Case Manager must be notified by telephone immediately. All missed visits must be reported in writing on the

"Weekly Missed/Attempted Visit Report" form to the Case Manager on Monday of each week.

(5) The DSP may not bill for missed visits.

b. Attempted Visits

(1) An attempted visit occurs when the Respite Care Worker arrives at the home and is unable to provide services because the client is not at home or refuses services.

(2) If an attempted visit occurs:

(a) The DSP may not bill for the attempted visits.

(b) The Supervisor will contact the client to determine the reason why the client was not present or why services were refused. Documentation of this discussion must be in the client's file.

(c) The DSP will notify the Case Manager within one (1) day after second attempted visit whenever two attempted visits occur within the SAME week.

7. Changes in Services

a. The DSP will notify the Case Manager within one (1) working day of the following changes:

(1) Client's condition and/or circumstances have changed and the Plan of Care no longer meets the client's needs;

(2) Client does not appear to need Respite Care;

(3) Client dies or moves out of the service area;

(4) Client indicates Respite Care Service is not wanted;

(5) Client loses Medicaid financial eligibility;

(6) When services can no longer be provided.

b. The Case Manager will notify the DSP immediately if a client becomes medically and financially ineligible for waiver services.

The Case Manager must verify Medicaid eligibility on a monthly basis.

c. If the DSP identifies additional duties that would be beneficial to the client's care, but are not specified on the Plan of Care, the DSP shall contact the Case Manager to discuss having these duties added.

(1) The Case Manager will review the DSP's request to modify services and respond within one (1) working day of the request.

(2) The Case Manager will approve any modification of duties to be performed by the Respite Care and re-issue the Service Authorization Form accordingly, if he/she concurs with the request.

(3) Documentation of any changes in a Plan of Care will be maintained in the client's file.

(a) If the total number of hours of service is changed, a new Service Authorization Form is required from the Case Manager.

(b) If the types or times of services are changed, a new Service Authorization Form is required from the Case Manager.

(c) If an individual declines Respite Care or has become ineligible for services, a Service Authorization Form for termination is required from the Case Manager.

8. Documentation and Record-Keeping

a. The DSP shall maintain a record keeping system which documents the units of service delivered based on the Service Authorization Form. The client's file shall be made available to Medicaid, the Operating Agencies, or other agencies contractually required to review information upon request.

The DSP shall maintain a file on each client, which shall include the following:

(1) A current HCBS application;

(2) Both current and historical Service Authorization Forms specifying units, services, and schedule of Respite Care visits for the client;

(3) All service logs;

- The service log must be reviewed and initialed by the Nurse Supervisor at least once every two (2) weeks.

(4) Records of all missed or attempted visits;

(5) Records of all complaints lodged by clients or family members/responsible parties and any actions taken;

(6) Evaluations from all 60 day on-site supervisory visits to the client;

(7) The Service Authorization Form notifying the DSP Agency of termination, if applicable;

(8) The name of the primary caregiver.

b. The DSP will retain a client's file for at least five (5) years after services are terminated.

c. The DSP Agency shall comply with federal and state confidentiality laws and regulations in regard to client and employee files.

F. Rights, Responsibilities, and Service Complaints

1. The Case Manager has the responsibility of ensuring that the DSP has fulfilled its duty of properly informing the client of all rights and responsibilities and the manner in which service complaints may be registered.

2. The DSP Agency will inform the client/responsible party of their right to lodge a complaint about the quality of Respite Care Service provided and will provide information about how to register a complaint with the Case Manager as well as the Alabama Medicaid Agency.

a. Complaints which are made against Respite Care Workers will be investigated by the DSP and documented in the client's file.

b. All complaints to be investigated will be referred to the Respite Care Worker Supervisor who will take appropriate action.

c. The Respite Care Worker Supervisor will take any action necessary and document the action taken in the client's and employee's files.

d. The Respite Care Worker Supervisor will contact the Case Manager by letter or telephone about any complaint and any corrective action taken.

3. The DSP must maintain documentation of all complaints, follow-up, and corrective action regarding the investigation of those complaints and documentation showing that they have completed with the requirements of this section.

G. Administrative Requirements

In addition to all conditions and requirements contained in the Scope of Services as well as in the contract, the DSP shall be required to adhere to the following stipulations:

l. The DSP Agency shall designate an individual to serve as the agency administrator. This does not have to be a full time position; however, the designated administrator must have the authority and responsibility for the direction of the DSP Agency. The DSP Agency shall notify the Operating Agency within (3) working days of a change in the agency administrator, address, or phone number.

2. The DSP will maintain an organizational chart indicating the administrative control and lines of authority for the delegation of responsibility down to the "hands on" client care level staff shall be set forth in writing. This information will be readily accessible to all staff. A copy of this information shall be forwarded to the Operating Agency at the time the contract is implemented. Any future revisions or modifications shall be distributed to all staff of the DSP Agency and to the Operating Agency.

3. Administrative and supervisory functions shall not be delegated to another agency or organization.

4. A list of the members of the DSP's governing body shall be made available to the Operating Agency and/or the Alabama Medicaid Agency upon request.

5. The DSP Agency must maintain an annual operating budget which shall be made available to the Operating Agency and/or the Alabama Medicaid Agency upon request.

6. During the life of the contract the DSP Agency shall acquire and maintain contract liability insurance to protect all paid and volunteer staff, including board members, from liability incurred while acting on behalf of the agency. Upon request, the DSP Agency shall furnish a copy of the insurance policy to the Operating Agency and/or the Alabama Medicaid Agency.

7. The DSP Agency shall ensure that key agency staff, including the agency administrator or the DSP Supervisor, be present during compliance review audits conducted by Medicaid, the Operating Agency and/or its agents.

8. The DSP Agency shall maintain an office which is open during normal business hours and staffed with qualified personnel.

9. The Direct Service Provider (DSP) shall provide it’s regularly scheduled holidays to the Operating Agency. The DSP Agency must not be closed for more than four (4) consecutive days at a time and then only if a holiday falls in conjunction with a weekend. The DSP shall also provide the regular hours of business operation. If a service is needed on a scheduled holiday, the service provider will ensure that the service is rendered.

10. The DSP Agency will maintain a Policy and Procedures Manual to describe how activities will be performed in accordance with the terms of the Operating Agency contract and the Waiver Document. The Policy and Procedure Manual should include the organization's Emergency Plan regarding service delivery.

H. Provider Experience

Providers of Respite Care must meet all provider qualifications prior to rendering the Respite Care Service.

All personnel with direct client contact or access to client information must have complete reference verification and statewide criminal background checks on file prior to client contact or access to client information.

SCOPE OF SERVICE
FOR
HOMEMAKER SERVICE
ELDERLY/DISABLED WAIVER

A. Definition

Homemaker Service provides assistance with general household activities such as meal preparation and routine housecleaning and tasks, such as, changing bed linens, doing laundry, dusting, vacuuming, mopping, sweeping, cleaning kitchen appliances and counters, removing trash, cleaning bathrooms, and washing dishes. This service may also include assistance with such activities as obtaining groceries and prescription medications, paying bills, and writing and mailing.

Homemaker Services is not an entitlement. It is based on the needs of individual client as reflected in the Plan of Care.

B. Objective

The objective of Homemaker Services (HM) is to preserve a safe and sanitary home environment, assist clients with home care management duties, to supplement and not replace care provided to clients, and to provide needed observation of clients participating in the Elderly/Disabled waiver.

C. Description of Service to be Provided

1. The unit of service is 15 minutes of direct Homemaker Service provided in the client's residence (except when shopping, laundry services, etc. must be done off-site). The amount of time authorized does not include the Homemaker's transportation time to or from the client's residence, or the Homemaker's break or mealtime.

2. The number of units and services provided to each client is dependent upon the individual client's needs as set forth in the Plan of Care.

   Medicaid will not reimburse for activities performed which are not within the scope of services.

3. No payment will be made for services that are not listed on the Plan of Care and the Service Authorization Form.

4. Homemaker Services duties include, but are not limited to, the following:

   a. Meal or snack preparation, meal serving, cleaning up afterwards;

b. General housekeeping includes cleaning (such as sweeping, vacuuming, mopping, dusting, taking out trash, changing bed linens, defrosting and cleaning the refrigerator, cleaning the stove or oven, cleaning bathrooms); laundry (washing clothes and linen, ironing, minor mending); and, other activities as needed to maintain the client in a safe and sanitary environment;

c. Essential shopping for food and other essential household or personal supplies which may be purchased during the same trip, and picking up prescribed medication;

d. Assistance with paying bills **(**which includes opening bills, writing checks but not signing them**)** and delivering payments to designated recipients on behalf of the client;

e. Assistance with communication which includes placing phone within client's reach and physically assisting client with use of the phone, orientation to daily events, paying bills, and writing letters;

f. Observing and reporting on client's condition;

g. The homemaker is not allowed to transport the client by vehicle in the performance of their task;

h. Reminding clients to take medications;

i. Observing and reporting on home safety. The Homemaker service worker will insure that the client is residing in a safe environment. Ensuring home safety means that the worker will have a general awareness of the home's surroundings and any concerns with safety issues will be reported to the Homemaker Supervisor as well as the case manager for follow up.

Note: Under no circumstances should any type of skilled medical or nursing service be performed by a Homemaker.

5. The Direct Service Provider (DSP) is not responsible for providing funds, supplies, or groceries to perform Homemaker Services.

D. <u>Staffing</u>

The DSP must provide all of the following staff positions through employment and/or subcontractual arrangements.

1. All Homemaker Supervisors will have the following qualifications:

a. High school diploma or equivalent;

b. Be able to evaluate homemakers in terms of their ability to perform assigned duties and relate to the client;

c. Have the ability to coordinate or provide orientation and in-service training to Homemaker Workers on either an individual basis or in a group setting;

d. Submit to a program for the testing, prevention, and control of tuberculosis annually;

e. Must have references which will be verified thoroughly and documented in the DSP personnel file. References must include statewide criminal background checks (including sex offender registry), previous employers, and the Nurse Aide Registry (if applicable);

f. Have the ability to provide appropriate follow-up regarding a client/caregiver and/or Case Manager's dissatisfaction, complaints or grievances regarding the provision of Homemaker service;

g. Have the ability to evaluate the Homemaker Worker (HM Worker) in terms of his/her ability to carry out assigned duties and relate to the client;

h. Possess a valid, picture identification.

2. All individuals providing Homemaker Service must meet the following qualifications:

a. Be able to read and write;

b. Submit to a program for the testing, prevention, and control of tuberculosis annually;

c. Have references which will be verified thoroughly and documented in the DSP personnel file. References must include statewide background checks (including sex offender registry), previous employers, and the Nurse Aide Registry (if applicable);

d. Be able to work independently on an established schedule;

e. Possess a valid, picture identification;

f. Be able to follow the Plan of Care with minimal supervision;

g. Complete a probationary period determined by the employer with continued employment contingent on completion of a Homemaker in-service training program.

3. Minimum Training Requirements for Homemakers:

The Homemaker training program should stress the physical, emotional and developmental needs of the population served, including the need for respect of the client, his/her privacy, and his/her property. The minimum training requirement must be completed prior to initiation of service with a client. The DSP is responsible for providing and/or conducting the training. The Homemaker training program must be approved by the Operating Agency. Proof of the training must be recorded in the personnel file.

The annual in-service training is in addition to the training required prior to the provision of care.

All Homemakers must have at least six (6) hours, in-service training annually from the following areas:

a. Maintaining a safe and clean environment;

b. Providing care including individual safety, laundry, serve and prepare meals, and household management;

c. First aid in emergency situations;

d. Fire and safety measures;

e. Client rights;

f. Record keeping; such as,

- A service log signed by the client or family member/ responsible person and Homemaker Worker to document what services were provided for the client in relation to the Plan of Care.

- Submitting a written summary to the Homemaker Worker Supervisor of any problems with client, client's home or family. The Supervisor in return should notify the Case Manager.

g. Communication skills;

h. Basic infection control/Universal Standards;

i. Other areas of training as appropriate or as mandated by the Operating Agency.

4. The DSP will be responsible for providing a minimum of six (6) hours of relevant in-service training per calendar year for each Homemaker Worker. In-service training is in addition to Homemaker Worker orientation training. For Homemaker Workers hired during the calendar year, this in-service

requirement may be prorated based on date of employment as a Homemaker Worker.

5. Documentation of the training provided shall include topic, date, name and title of trainer, objective of the training, outline of content, length of training, list of trainees and location.

6. Topics for specific in-service training may be mandated by Medicaid or the Operating Agency.

7. In-service training may entail demonstration of maintaining a safe and clean environment for the client. Additional training may be provided as deemed necessary by the DSP. Any self-study training programs are limited to four (4) hours annually and must be approved for content and credit hours by Medicaid and the Operating Agency, prior to the planned training. The DSP shall submit proposed program(s) to the Operating Agency at least 45 days prior to the planned implementation.

8. The DSP must have an ongoing infection control program in effect and training on Universal Standards and an update on infection control shall be included as part of the six (6) hours required in-service for all Homemaker Workers each calendar year.

9. The DSP Agency shall maintain records on each employee, which shall include the following:

   a. Application for employment;

   b. Job description;

   c. Statewide criminal background checks and references;

   d. Record of health with annual tuberculin tests (this includes <u>any</u> staff member that has direct client contact);

   e. Record of pre-employment and in-service training;

   f. Orientation;

   g. Evaluations;

   h. Supervisory visits;

   i. Copy of photo identification;

j. Records of all complaints/incidents lodged by the client/family/responsible party and action taken;

k. Reference contacts;

l. Other forms as required by state and federal law, including agreements regarding confidentiality.

E. Procedures for Service

1. The Case Manager will submit a Service Authorization Form and Plan of Care to the DSP Agency authorizing Homemaker Service and designating the units, frequency, beginning date of service, and types of duties in accordance with the individual client's needs.

2. The DSP Agency will initiate Homemaker Service within three (3) working days of the designated START DATE on the Service Authorization Form in accordance with the following:

   a. Services must not be provided prior to the authorized start date as stated on the Service Authorization Form.

   b. The DSP Agency will adhere to the services and schedule as authorized by the Case Manager on the Service Authorization Form. No payment will be made for services unless authorized.

3. The DSP Agency may recommend to the Case Manager any changes in the hours, times, or specified duties requested. The Case Manager will review a client's Plan of Care within one (1) working day of the DSP's request to modify the Plan of Care. A change in the Service Authorization Form will be submitted to the DSP Agency if the Case Manager concurs with the request.

4. Homemakers will maintain a separate service log to document their delivery of services.

   a. The Homemaker shall complete a service log daily. The service log will reflect the types of services provided, the number of hours of service, and the times of service.

   b. The service log must be signed upon each visit by the client, or family member/responsible party and the Homemaker Worker. In the event the client is not physically able to sign and the family member/responsible party is not present to sign, then the Homemaker must document the reason the log was not signed by the client or family member/responsible party.

c. The service log will be reviewed and signed by the Homemaker Supervisor at least once every two (2) weeks. Service logs will be retained in the client's file.

d. Client visits may be recorded electronically via telephony. Electronic documentation will originate from the client's residence as indicated by the phone number at the residence. A monthly report of phone number exceptions will be maintained with written documentation giving the reason the electronic documentation did not originate at the client's residence, e.g., phone line down, client does not have phone. These electronic records may be utilized in place of client signatures.

5. Provision of Service Authorized:

a. Homemaker Service cannot be provided at the same time as other authorized waiver services are being provided, except for case management.

b. Services provided by relatives or friends may be covered only if relatives or friends meet the qualifications as providers of care. However, providers of service cannot be a parent/step-parent/legal guardian of a minor or a spouse of the individual receiving services, when the services are those that these persons are legally obligated to provide. There must be strict controls to ensure that payment is made to the relatives or friends as providers only in return for homemaker services. Additionally, there must be adequate justification as to why the relative or friend is the provider of care and there is documentation in the case management file showing that the family member is a qualified provider and the lack of other qualified providers in remote areas. The case manager will conduct an initial assessment of qualified providers in the area of which the client will be informed. The case manager must document in the client's file the attempts made to secure other qualified providers before a relative or friend is considered. The case manager, along with the DSPs, will review the compiled information in determining the lack of qualified providers for client's living in a remote area.

6. Monitoring of Service

Homemaker Service must be provided under the supervision of the individual who meets the qualifications in D.1. and will:

a. Make the initial visit prior to the start of Homemaker Service for the purpose of reviewing the plan of care, providing the client written information regarding rights and responsibilities and how to register

complaints, and discussing the provision and supervision of the service(s)."

The initial visit should be held at the client's place of residence and should include the Case Manager, the Homemaker Supervisor, the client and caregiver if feasible. It is advisable to also include the Homemaker Worker in the initial visit.

b. Be immediately accessible by phone during the time Homemaker Service is being provided. Any deviation from this requirement must be prior approved in writing by the Operating Agency and the Alabama Medicaid Agency. If this position becomes vacant the Operating Agency and the Alabama Medicaid Agency must be notified within 24 hours.

c. Provide and document supervision of, training for, and evaluation of Homemaker Workers according to the requirements in the approved waiver document.

d. Provide on-site (client's residence) supervision of at a minimum of every 60 days for each client. Supervisory visits must be documented in the individual client record. Supervisors will conduct on-site supervision more frequently if warranted by complaints or suspicion of substandard performances by the Homemaker Worker. In the event the on-site supervisory visit cannot be completed in a timely manner due to the client's being inaccessible, the supervisory visit must be completed within five (5) working days following resumption of Homemaker Service. Documentation regarding this action should be in the DSP client record. Client must be present for visit.

e. The DSP must complete the 60 day supervisory review which includes, at a minimum, assurance that the services are being delivered consistent with the Plan of Care and the Service Authorization Form in an appropriate manner, assurance that the client's needs are being met, and a brief statement regarding the client's condition. A copy of the supervisory visit must be submitted to the Case Manager within 10 calendar days after the 60 day supervisory review.

f. Assist Homemaker Workers as necessary as they provide individual Homemaker Service as outlined in the Plan of Care. Any supervision/ assistance given must be documented in the individual client's record.

g. The Homemaker Supervisor must provide direct supervision of each Homemaker Worker with at least one (1) assigned client at a minimum of every six (6) months. Direct supervisory visits must be documented in the Homemaker Worker's personnel record.

- Direct supervision may be carried out in conjunction with an on-site supervisory visit.
- Client and worker must be present.

The Homemaker Supervisor will provide and document the supervision, training, and evaluation of Homemaker Workers according to the requirements in the approved Waiver Document.

7. Missed Visits and Attempted Visits

a. Missed Visits

(1) A missed visit occurs when the client is at home waiting for scheduled services, but the services are not delivered.

(2) The DSP shall have a written policy assuring that when a Homemaker Worker is unavailable, the Supervisor assesses the need for services and makes arrangements for a substitute to provide services as necessary.

b. Clients who are designated by the Case Manager as being at-risk should be given first priority when Homemaker Service visits must be temporarily prioritized and/or reduced by the DSP.

(1) If the Supervisor sends a substitute, the substitute will complete and sign the daily log after finishing duties. If a substitute Homemaker Worker was offered to the client/caregiver, but refused, this should be documented in the DSP client record on the "Weekly Missed/Attempted Visit Report."

(2) If the Supervisor does not send a substitute, the Supervisor will contact the client and inform them of the unavailability of the Homemaker Worker.

(3) The DSP will document missed visits in the client's files.

(4) Whenever the DSP determines that services cannot be provided to an at-risk client as authorized, the Case Manager must be notified by telephone immediately. All missed/attempted visits for one week and the reason for the missed/attempted visit must be reported in writing on the "Weekly Missed/ Attempted Visit Report" form to the Case Manager on Monday of each week. Any exception to the use of this form must be approved by the Operating Agency and the Alabama Medicaid Agency.

(5) The DSP may not bill for missed visits.

c. Attempted Visits

(1) An attempted visit occurs when the Homemaker Worker arrives at the home and is unable to provide services because the client is not at home or refuses services.

(2) If an attempted visit occurs:

(a) The DSP may not bill for the attempted visits.

(b) The Supervisor will contact the client or family member to determine the reason why the client was not present or why services were refused. Documentation of this discussion must be in the client's file.

(c) The DSP will notify the case manager within one (1) working day after the second attempted visit whenever two (2) attempted visits occur within the SAME week.

8. Changes in Services

a. The DSP will notify the Case Manager within one (1) working day of the following changes:

(1) Client's condition and/or circumstances have changed and the Plan of Care no longer meets the client's needs:

(2) Client does not appear to need Homemaker Service;

(3) Client dies or moves out of the service area;

(4) Client indicates Homemaker Service is not wanted;

(5) Client loses Medicaid financial eligibility;

(6) When services can no longer be provided.

b. The Case Manager will notify the DSP immediately if a client becomes medically or financially ineligible for waiver services.

c. If the DSP identifies additional duties that may be beneficial to the client's care, but are not specified on the Plan of Care, the DSP shall contact the Case Manager to discuss having these duties added.

(1) The Case Manager will review the DSP's request to modify services and respond within one (1) working day of the request.

(2) The Case Manager will approve any modification of duties to be performed by the HMW and re-issue the Service Authorization Form accordingly, if he/she concurs with the request.

(3) Documentation of any change in the Plan of Care or Service Authorization Form will be maintained in the client's file.

(a) If the total number of hours or types of services are changed, a new Service Authorization Form is required from the Case Manager.

(b) If an individual declines Homemaker Service or has become ineligible for services, a Service Authorization Form for termination is required from the Case Manager.

9. Documentation and Record-Keeping

a. The DSP shall maintain a record keeping system for each client that documents the units of service delivered based on the Service Authorization Form. The client's file shall be made available to Medicaid, the operating agencies, or other agencies contractually required to review information upon request.

b. The DSP shall maintain a file on each client, which shall include the following:

(1) A current HCBS application;

(2) Both current and historical Service Authorization Forms specifying units, services, and schedule of Homemaker visits for the client;

(3) Documentation of client specific assistance and/or training rendered by the Supervisor to a Homemaker Worker;

(4) All service logs;

(a) The service log must be reviewed and initialed by the Homemaker Supervisor at least once every two (2) weeks.

(5) Records of all missed or attempted visits;

(6) Records of all complaints lodged by clients or family members/responsible parties and any actions taken; and,

(7) Evaluations from all 60 day on-site supervisory visits to the client;

(8) The Service Authorization Form notifying the DSP Agency of termination, if applicable;

(9) Initial visit for in-home services;

(10) Any other notification to Case Manager;

(11) Permission statements to release confidential information, as applicable.

c. The DSP will retain a client's file for at least five (5) years after services are terminated.

d. The DSP Agency shall comply with federal and state confidentiality laws and regulations in regard to client and employee files.

F. Rights, Responsibilities, and Service Complaints

1. The Operating Agency has the responsibility of ensuring that the DSP has fulfilled its duty of properly informing the client of all rights and responsibilities and the manner in which service complaints may be registered.

2. The DSP Agency will inform the client/responsible party of their right to lodge a complaint about the quality of Homemaker Service provided and will provide information about how to register a complaint with the Case Manager as well as the Alabama Medicaid Agency.

a. Complaints which are made against the HMW will be investigated by the DSP Agency and documented in the client’s file.

b. All complaints which are to be investigated will be referred to the HMW Supervisor who will take appropriate action.

c. The HMW Supervisor will take any action necessary and document the action taken in the client’s and/or the employee’s files, whichever is most appropriate based on the nature of the complaint.

d. The HMW Supervisor will contact the Case Manager by letter or telephone about any complaint and any corrective action taken.

3. The DSP must maintain documentation of all complaints, follow-up, and corrective action regarding the investigation of those complaints and documentation showing that they have complied with the requirements of this section.

G. Administrative Requirements

In addition to all conditions and requirements contained in the Scope of Services as well as in the contract, the DSP shall be required to adhere to the following stipulations:

1. The DSP Agency shall designate an individual to serve as the agency administrator who shall employ qualified personnel and ensure adequate staff education, in-services training and perform employee evaluations. This does not have to be a full time position; however, the designated administrator must have the authority and responsibility for the direction of the DSP Agency. The DSP Agency shall notify the Operating Agency within three (3) working days of a change in the agency administrator, address, phone number or an extended absence of the agency administrator.

2. The DSP will maintain an organizational chart indicating the administrative control and lines of authority for the delegation of responsibility down to the "hands on" client care level staff shall be set forth in writing. This information will be readily accessible to all staff. A copy of this information shall be forwarded to the Operating Agency at the time the contract is implemented. Any future revisions or modifications shall be distributed to all staff of the DSP Agency and the Operating Agency.

3. Administrative and supervisory functions shall not be delegated to another agency or organization.

4. A list of the members of the DSP's governing body shall be made available to the Operating Agency and/or the Alabama Medicaid Agency upon request.

5. The DSP Agency must maintain an annual operating budget which shall be made available to the Operating Agency and/or the Alabama Medicaid Agency upon request.

6. During the life of the contract the DSP Agency shall acquire and maintain liability insurance to protect all paid and volunteer staff, including board members, from liability incurred while acting on behalf of the agency. Upon request, the DSP Agency shall furnish a copy of the insurance policy to the Operating Agency and/or the Alabama Medicaid Agency.

7. The DSP Agency shall ensure that key agency staff, including the agency administrator or the DSP Supervisor, be present during compliance review audits conducted by Medicaid, the Operating Agency and/or its agents.

8. The DSP Agency shall maintain an office which is open during normal business hours and staffed with qualified personnel.

9. The Direct Service Provider (DSP) shall provide its regularly scheduled holidays to the Operating Agency. The DSP Agency must not be closed for more than four (4) consecutive days at a time and then only if a holiday falls in conjunction with a weekend. The DSP shall also provide the regular hours of business operation. If a service is needed on a scheduled holiday, the service provider will ensure that the service is rendered.

10. The DSP Agency will maintain a Policy and Procedures Manual to describe how activities will be performed in accordance with the terms of the Operating Agency contract and the Waiver Document. The Policy and Procedure Manual should include the organization's Emergency Plan regarding service delivery.

H. Provider Experience

Providers of Homemaker Service must meet all provider qualifications prior to rendering the Homemaker Service.

All personnel with direct client contact or access to client information must have complete reference verification and statewide criminal background checks on file prior to client contact or access to client information.

SCOPE OF SERVICE
FOR
COMPANION SERVICE
ELDERLY/DISABLED WAIVER

A. Definition

Companion Service is non-medical assistance, observation, supervision and socialization, provided to a functionally impaired adult. Companions may provide limited assistance or supervise the individual with such tasks as activities of daily living, meal preparation, laundry and shopping, but do not perform these activities as discrete services. The Companion may also perform housekeeping tasks which are incidental to the care and supervision of the individual. Companion Service is provided in accordance with a therapeutic goal as stated in the Plan of Care, and is not purely diversional in nature. The therapeutic goal may be related to client safety and/or toward promoting client independence or toward promoting the mental or emotional health of the client.

Companion Service is not an entitlement. It is provided based on the needs of the individual client as reflected in the Plan of Care.

B. Objective

The objective of Companion Service is to provide support and supervision that is focused on safety, non-medical care and socialization for clients participating in the Elderly and Disabled Waiver.

C. Description of Service to be Provided

1. The unit of service will be 15 minutes of direct Companion Service provided to the client. The maximum number of units that can be authorized may not exceed four (4) hours daily. The number of units per visit must be indicated on the Plan of Care and the Service Authorization Form. The amount of time authorized does not include the Companion Worker's transportation time to or from the client's home, or the Companion Worker's break or mealtime.

2. The number of units and service provided to each client is dependent upon the individual client's needs as set forth in the client's Plan of Care which is established by the Case Manager and subject to approval by the Medicaid Agency.

   Medicaid will not reimburse for activities performed which are not within the scope of services defined.

3. Companion Service includes:

a. Supervision/observation of daily living activities, such as,

(1) Reminding client to bathe and take care of personal grooming and hygiene;

(2) Reminding client to take medication;

(3) Observation/supervision of snack, meal planning and preparation, and/or eating;

(4) Toileting or maintaining continence.

b. Accompanying the client to necessary medical appointments, grocery shopping, and obtaining prescription medications. The Companion Worker is not allowed to transport clients, only to accompany them.

c. Supervision/assistance with laundry.

d. Performance of housekeeping duties that are essential to the care of the client.

e. Assist with communication.

f. Reporting observed changes in the client's physical, mental or emotional condition.

g. Observing/reporting home safety. The Companion Worker will ensure that the client is residing in a safe environment. Ensuring home safety means the Companion Worker will have a general awareness of the home's surroundings and any concerns with safety issues will be reported to the Companion Worker Supervisor as well as to the Case Manager for follow up.

D. Staffing

The DSP must provide all of the following staff positions through employment or sub contractual arrangements.

1. Companion Worker Supervisors' Qualifications

All Companion Worker Supervisors will have the following qualifications:

a. High school diploma or equivalent;

b. Be able to evaluate Companion Worker in terms of their ability to perform assigned duties and communicate with the individuals;

c. Be able to assume responsibility for in-service training for Companion Workers by individual instructions, group meetings, or workshops;

d. Submit to programs for the testing, prevention, and control of tuberculosis annually;

e. Criminal background check (including sex offender registry);

f. Have references which are verified thoroughly by the DSP and documented in the personnel file. References must include previous employers and the Nurse Aide Registry;

g. Have the ability to provide appropriate follow-up regarding a client/caregiver and/or Case Managers dissatisfaction, complaints or grievances regarding the provision of Companion Service;

h. Possess a valid, picture identification.

2. All Companions Workers must meet the following qualifications:

a. Be able to read and write;

b. Submit to programs for the testing, prevention, and control of tuberculosis annually;

c. Statewide criminal background check (including sex offender registry);

d. Have references which are verified thoroughly by the DSP and documented in the personnel file. References must include previous employers and the Nurse Aide Registry;

e. Possess a valid, picture identification;

f. Be able to follow the Plan of Care with minimal supervision unless there is a change in the client's condition;

g. Complete a probationary period determined by the employer with continued employment contingent on completion of the in-service training program.

3. Minimum Training Requirements for Companion Worker

The Companion Worker training program should stress the physical, emotional and developmental needs of the population served, including the need for respect of the client, his/her privacy, and his/her property. The minimum training requirement must be completed prior to initiation of service with a client. The DSP is responsible for providing/or conducting the training. The Companion Worker training program must be approved by the Operating Agency. Proof of the training must be recorded in the personnel file.

The Companion Worker must successfully complete orientation training in areas specified below prior to providing Companion Services or have documentation of personal, volunteer, or paid experience in the care of adults, families, and/or the disabled, home management, household duties, preparation of food, and be able to communicate observations verbally and in writing.

a. Meal planning and preparation;

b. Laundry/shopping;

c. Provision of care and supervision including individual safety;

d. First aid in emergency situations;

e. Documentation of services provided per written instructions;

f. Basic infection Control/Universal Standards;

g. Fire and safety measures;

h. Assist clients with medications;

i. Communication skills;

j. Client rights;

k. Other areas of training as appropriate or as mandated by the Operating Agency.

4. The annual in-service training will be provided by the DSP and is in addition to the training required prior to job placement.

5. All Companion Workers must have at least six (6) hours in-service training annually. For Companion Workers hired during the calendar year, this in-service requirement may be prorated based on date of employment as a Companion Worker.

6. Documentation of the training provided shall include topic, date, name and title of trainer, objective of the training, outline of content, length of training,

list of trainees and location.

7. Topics for specific in-service training may be mandated by the Operating Agency.

8. In-service training may entail demonstration of providing care to the client. Additional training may be provided as deemed necessary by the DSP. Any self-study training programs are limited to four (4) hours annually and must be approved for content and credit hours by the Operating Agency prior to the planned training. The DSP shall submit the proposed program(s) to the Operating Agency at least 45 days prior to the planned implementation.

9. The DSP must have an ongoing infection control program in effect and training on Universal Standards and an update on infection control shall be included as part of the six (6) hours required in-service for all Companion Workers each calendar year.

10. The DSP Agency shall maintain records on each employee which shall include the following:

    a. Application for employment;

    b. Job description;

    c. Statewide criminal background check (including sex offender registry);

    d. References which are verified thoroughly by the DSP and documented in the personnel file;

    e. Record of health including annual tuberculin tests for <u>any</u> staff member that has direct client contact;

    f. Record of pre-employment and in-service training;

    g. Orientation;

    h. Evaluations;

    i. Supervisory visits;

    j. Copy of photo identification;

    k. Reference contacts;

    l. Other forms as required by State and Federal law, including agreements regarding confidentiality.

E. Procedure for Service

1. The Case Manager will submit a Service Authorization Form and a copy of the Plan of Care to the DSP Agency, authorizing Companion Service and designating the units, frequency, beginning date of service, and types of duties in accordance with the individual client's needs as set forth in the Plan of Care.

2. The DSP Agency will initiate Companion Service within three (3) working days of the designated START DATE on the Service Authorization Form in accordance with the following:

   a. Services must **not** be provided prior to the authorized start date as stated on the Service Authorization Form:

   b. The DSP Agency will adhere to the services and schedule as authorized by the Case Manager on the Service Authorization Form. No payment will be made for services unless authorized and listed on the Plan of Care.

3. Provision of Service Authorized:

   a. Companion Service cannot be provided at the same time as other authorized waiver services are being provided, except for case management.

   b. Services provided by relatives or friends may be covered only if relatives or friends meet the qualifications as providers of care. However, providers of service cannot be a parent/step-parent/legal guardian of a minor or a spouse of the individual receiving services, when the services are those that these persons are legally obligated to provide. There must be strict controls to assure that payment is made to the relatives or friends as providers only in return for companion services. Additionally, there must be adequate justification as to why the relative or friend is the provider of care and there is documentation in the case management file showing that the family member is a qualified provider and the lack of other qualified providers in remote areas. The case manager will conduct an initial assessment of qualified providers in the area of which the client will be informed. The case manager must document in the client's file the attempts made to secure other qualified providers before a relative or friend is considered. The case manager, along with the DSPs, will review the compiled information in determining the lack of qualified providers for client's living in a remote area.

   c. The Companion Worker is not allowed to provide transportation when he/she is accompanying a client.

   d. Companion service is only available to those clients who reside alone.

4. Companion Workers will maintain a separate service log for each client to document their delivery of services.

   a. The Companion Worker shall complete a service log that will reflect the types of services provided, the number of hours of service, and the date and time of the service.

   b. The service log must be signed upon each visit by the client, or family member/responsible party and the Companion Worker. In the event the client is not physically able to sign and the family member/ responsible party is not present to sign, then the Companion Worker must document the reason the log was not signed by the client or family member/responsible party.

   c. The service log will be reviewed and signed by the Companion Worker Supervisor at least once every two (2) weeks. Service logs will be retained in the client's file.

   d. Client visits may be recorded electronically via telephony. Electronic documentation will originate from the client's residence as indicated by the phone number at the residence. A monthly report of phone number exceptions will be maintained with written documentation giving the reason the electronic documentation did not originate at the client's residence, e.g., phone line down, client does not have phone, client staying with relatives. These electronic records may be utilized in place of client signatures.

5. Monitoring of Service

   a. The Companion Worker Supervisor will visit the home of clients to monitor services.

      (1) The Companion Worker Supervisor will make the initial visit to the client's residence prior to the start of Companion Service for the purpose of reviewing the plan of care, providing the client written information regarding rights and responsibilities, how to register complaints, and discussing the provisions and supervision of the service(s).

      The initial visit should be held at the client's place of residence and should include the Case Manager, the Companion Supervisor, the client and caregiver if feasible. It is advisable to also include the CompanionWorker in the initial visit.

(2) The Companion Worker Supervisor will provide on-site supervision at the client's place of residence at a minimum of every 60 days for each client. Supervisors will conduct on-site supervision more frequently if warranted by complaints or suspicion of substandard performance by the Companion Worker. Supervisory visits must be documented in the individual client record. Client must be present for visit.

The DSP must complete the 60 day supervisory review which includes, at a minimum, assurance that the services are being delivered consistent with the Plan of Care and the Service Authorization Form in an appropriate manner, assurance that the client's needs are being met, and a brief statement regarding the client's condition. A copy of the supervisory visit must be submitted to the Case Manager within 10 calendar days after the 60 day supervisory review.

In the event the on-site supervisory visit cannot be completed in a timely manner due to the client being inaccessible, the supervisory visit must be completed within five (5) working days following resumption of Companion Service. Documentation regarding this action should be in the DSP client file.

(3) Each Companion Worker supervisory visit will be documented in the client's file. The Companion Worker Supervisor's report of the on-site visits will include, at a minimum:

(a) Documentation that services is being delivered consistent with the Plan of Care;

(b) Documentation that the client's needs are being met;

(c) Reference to any complaints which the client or family member/responsible party have lodged and action taken;

(d) A brief statement regarding any changes in the client's Companion Service needs;

(e) The Companion Service Supervisor will provide assistance to Companion Worker as necessary.

(f) Companion Worker Supervisor must be immediately accessible by phone during the time Companion Service is being provided. Any deviation from this requirement must

be prior approved in writing by the Operating Agency and the Alabama Medicaid Agency. If this position becomes vacant, the Operating Agency and the Alabama Medicaid Agency must be notified in writing within 24 hours if the position becomes vacant.

(g) The Companion Worker Supervisor must provide direct supervision of each Companion Worker with at least one (1) assigned client at a minimum of every six (6) months. Direct supervisory visits must be documented in the Companion Worker's personnel record.

- Direct supervision may be carried out in conjunction with an on-site supervisory visit.
- Client and worker must be present.

(h) The Companion Worker Supervisor will provide and document the supervision, training, and evaluation of Companion Workers according to the requirements in the approved Waiver Document.

6. Missed Visits, and Attempted Visits

a. Missed Visits

(1) A missed visit occurs when the client is at home waiting for scheduled services, but the services are not delivered.

(2) The DSP shall have a written policy assuring that when a Companion Worker is unavailable, the Companion Worker Supervisor will assess the need for services and makes arrangements for a substitute to provide services as necessary.

Clients who are designated by the Case Manager as being at-risk should be given first priority when Companion Service visits must be temporarily prioritized and/or reduced by the DSP.

(a) If the Companion Worker Supervisor sends a substitute, the substitute will complete and sign the service log after finishing duties.

(b) If the Companion Worker Supervisor does not send a substitute, the Companion Worker Supervisor will contact the client and inform them of the unavailability of the Companion Worker.

(3) The DSP will document missed visits in the client's files.

(4) Whenever the DSP determines that services cannot be provided to an at-risk client as authorized, the Case Manager must be notified by telephone immediately. All missed/attempted visits for one week and the reason for the missed/attempted visit must be reported in writing on the "Weekly Missed/ Attempted Visit Report" form to the Case Manager on Monday of each week. Any exception to the use of this form must be approved by the Operating Agency and the Alabama Medicaid Agency.

(5) The DSP may not bill for missed visits.

b. Attempted Visits

(1) An attempted visit occurs when the Companion Worker arrives at the home and is unable to provide services because the client is not at home or refuses services.

(2) If an attempted visit occurs:

(a) The DSP may not bill for the attempted visits.

(b) The Companion Worker Supervisor will contact the client to determine the reason why the client was not present or why services were refused, and document in the client's file.

(c) The DSP will notify the Case Manager promptly whenever an attempted visit occurs and will notify the CM within one (1) working day after the second attempted visit whenever two attempted visits occur within the SAME week.

7. Changes in Services

a. The DSP will notify the Case Manager within one (1) working day of the following changes:

(1) Client's condition and/or circumstances have changed and that the Plan of Care no longer meets the client's needs;

(2) Client does not appear to need Companion Service;

(3) Client dies or moves out of the service area;

(4) Client indicates Companion Service is not wanted;

(5) Client loses Medicaid financial eligibility;

(6) When services can no longer be provided.

b. The Case Manager will notify the DSP within one (1) working day if a client becomes ineligible for waiver services.

c. If the DSP identifies additional duties that may be beneficial to the client's care, but are not specified on the Plan of Care, the DSP shall contact the Case Manager to discuss having these duties added.

(1) The Case Manager will review the DSP's request to modify services and respond within one (1) working day of the request.

(2) The Case Manager will approve any modification of duties to be performed by the Companion and re-issue the Service Authorization Form accordingly.

(3) Documentation of any changes in a Plan of Care will be maintained in the client's file.

(a) If the total number of hours of service is changed, a new Service Authorization Form is required from the Case Manager.

(b) If the types or times of services are changed, a new Service Authorization Form is required from the Case Manager.

(c) If an individual declines Companion Service or has become ineligible for services, a Service Authorization Form for termination is required from the Case Manager.

8. Documentation and Record-Keeping

a. The DSP shall maintain a record keeping system for each client that documents the units of service delivered based on the Service Authorization Form. The client's file shall be made available upon request to Medicaid, the operating agencies, or other agencies contractually required to review information.

The DSP shall maintain a file on each client, which shall include the following:

(1) A current HCBS application;

(2) Both current and historical Service Authorization Forms specifying units, services, and schedule of Companion visits for the client;

(3) Documentation of client-specific assistance and/or training rendered by the supervisor to a Companion Worker;

(4) All service logs;

(5) Records of all missed or attempted visits;

(6) Records of all complaints lodged by clients or family members/responsible parties and any actions taken;

(7) Evaluations from all 60 day on-site supervisory visits to the client;

(8) The Service Authorization Form notifying the DSP Agency of termination, if applicable;

(9) Initial visit for in-home services;

(10) Any other notification to Case Manager;

(11) Permission statements to release confidential information, as applicable.

b. The DSP will retain a client's file for at least five (5) years after services are terminated.

c. The DSP Agency shall comply with federal and state confidentiality laws and regulations in regard to client and employee files.

F. Rights, Responsibilities, and Service Complaints

1. The Operating Agency has the responsibility of ensuring that the DSP has fulfilled its duty of properly informing the client of all rights and responsibilities and the manner in which service complaints may be registered.

2. The DSP Agency will inform the client/responsible party of their right to lodge a complaint about the quality of Companion Service provided and will provide information about how to register a complaint with the Case Manager as well as the Alabama Medicaid Agency.

a. Complaints which are made against Companion Workers will be investigated by the DSP and documented in the client's file.

b. All complaints to be investigated will be referred to the Companion Worker Supervisor who will take appropriate action.

c. The Companion Worker Supervisor will take any action necessary and document the action taken in the client's and/or the employee's files, whichever is most appropriate based on the nature of the complaint.

d. The Companion Worker Supervisor will contact the Case Manager by letter or telephone about any complaint and any corrective action taken.

3. The DSP must maintain documentation of all complaints, follow-up, and corrective action regarding the investigation of those complaints and documentation showing that they have complied with the requirements of this section.

G. Administrative Requirements

In addition to all conditions and requirements contained in the Scope of Service as well as in the contract with the Operating Agency, the DSP shall be required to adhere to the following stipulations:

1. The DSP shall designate an individual to serve as the administrator who shall employ qualified personnel and ensure adequate staff education, in-service training, and perform employee evaluations. This does not have to be a full-time position; however, the designated administrator will have the authority and responsibility for the direction of Companion Service for the DSP Agency. The DSP Agency shall notify the operating agency within three (3) working days in the event of a change in the administrator, address, telephone number, or of an extended absence of the agency administrator.

2. The DSP will maintain an organizational chart indicating the administrative control and lines of authority for the delegation of responsibility down to the "hands on" client care level staff shall be set forth in writing. This shall be readily accessible to all staff. A copy of this information shall be forwarded to the Operating Agency at the time the contract is implemented. Any future revisions or modifications shall be distributed to all staff of the DSP Agency and to the Alabama Medicaid Agency and the Operating Agency.

3. Administrative and supervisory functions shall not be delegated to another organization.

4. A list of the members of the DSP's governing body shall be available to the Operating Agency and the Alabama Medicaid Agency upon request.

5. The DSP Agency will maintain a Policy and Procedures Manual to describe how activities will be performed in accordance with the terms of the Operating Agency contract and the waiver document. The Policy and Procedure Manual should include the organization's Emergency Plan regarding service delivery.

6. During the life of this contract the DSP shall acquire and maintain liability insurance to protect all paid and volunteer staff, including board members, from liability incurred while acting on behalf of the DSP. Upon request, the DSP shall furnish a copy of the insurance policy to the Operating Agencies and/or the Alabama Medicaid Agency.

7. The DSP shall conform to applicable federal, state and local health and safety rules and regulations, and have an on-going program to prevent the spread of

infectious diseases among its employee (such as making substitutions for ill Companion Workers and training Companion Workers in personal hygiene and proper food handling and storage).

8. The DSP shall maintain an office which will be open during normal business hours and staffed with qualified personnel.

9. The Direct Service Provider (DSP) shall provide its regularly scheduled holidays to the Operating Agency. The DSP Agency must not be closed for more than four (4) consecutive days at a time and then only if a holiday falls in conjunction with a weekend. The DSP shall also provide the regular hours of business operation. If a service is needed on a scheduled holiday, the service provider will assure that the service is rendered.

10. The DSP Agency must maintain an annual operating budget which shall be made available to the Operating Agency and/or the Alabama Medicaid Agency upon request.

H. Provider Experience

Providers of Companion Service must meet all provider qualifications prior to rendering the Companion Service.

All personnel with direct client contact or access to client information must have complete reference verification and statewide criminal background checks on file prior to client contact or client access.

SCOPE OF SERVICE

FOR
HOME DELIVERED MEALS
ELDERLY/DISABLED WAIVER

A. Definition

Home Delivered Meals are provided to an eligible individual age 21 or older who is unable to meet his or her nutritional needs. It must be determined that the nutritional needs of the individual can be addressed by the provision of home-delivered meals.

When specified in the Plan of Care, this service may include seven (7) or 14 frozen meals per week. A client may be authorized to receive seven (7) frozen meals plus seven (7) breakfast meals in lieu of 14 frozen meals. In addition, the service may include the provision of two (2) or more shelf-stable meals (not to exceed 6 meals per 6-month period) to meet emergency nutritional needs when authorized on the client's Plan of Care. Services during a disaster will be handled as outlined in "F" below.

Home Delivered Meals are not an entitlement. Provision is based on the needs of the individual client.

B. Objective

The objective of Home Delivered Meal Service is to provide at least one (1) nutritionally sound meal per day to adults unable to care for their nutritional needs because of a functional disability or dependency, who require nutritional assistance to remain in the community, and who do not have a caregiver available to prepare a meal for them.

C. Description of Service to be Provided

1. A Unit of Service is either one (1) package of frozen or one package of breakfast meals delivered once a week to a client's residence. Each package of meals contains seven (7) frozen meals or seven (7) breakfast meals. For shelf-stable meals, the unit of service is two (2) meals, packaged as individual meals and delivered to the client's residence. The types of meals available are:

   Frozen Meal--A frozen meal consists of an entree plus two (2) side dishes; fruit juice; bread; margarine; dessert; and milk. Meals are packed seven (7) meals/box and will contain the entree plus two (2) side dishes, fruit juice, bread, dessert, and margarine. Milk is delivered separately in the refrigerated form.

   Breakfast Meal--A breakfast meal consists of fortified cereal in an individual serving bowl; fruit or vegetable juice; bread; a fruit or yogurt; milk; and condiments (margarine, jelly, jam, cream cheese, peanut butter, syrup, etc.) All items are delivered in room temperature or refrigerated form. A meal pack will

contain seven (7) meals. This meal option may not be served alone. It must be served in conjunction with a unit of frozen meals.

Shelf-Stable Meal--A shelf-stable meal consists of an entree; fruit or vegetable juice; crackers or breadsticks; vegetable, soup, canned fruit, or dried fruit; cookie, snack cake, snack cracker, cereal, pudding, canned fruit, or dried fruit; and nonfat dry milk. Meals will be packaged as individual meals. The delivery meal pack will contain two (2) shelf-stable meals. Shelf-stable meals may only be provided when frozen meals have also been authorized.

2. The number of units of service provided to each client is dependent upon the individual client's needs and is set forth in the client's plan of care, established by the Case Manager in consultation with the client. The client must be identified as having difficulty in shopping and/or preparing appropriate, nutritious meals. The client must have adequate and appropriate means for storing and heating frozen meals, be capable of performing the simple tasks associated with storing and heating a frozen meal, or have other appropriate arrangements approved by the Case Manager.

   a. Clients authorized to receive one (1) unit of service per week will receive one 7-pack of frozen meals.

   b. Clients authorized to receive two (2) units of service per week will receive two 7-packs of frozen meals or a combination of one 7-pack of frozen meals and one 7-pack of breakfast meals.

   c. The maximum number of meals authorized per week will be 14 meals.
   d. Breakfast meals must be ordered in combination with frozen meals and may not be ordered alone.

   If the client attends an Adult Day Health (ADH) center five (5) days a week and receives two meals at the ADH center, the client will not be eligible for this service. If the client attends the center five (5) days a week and receive one meal daily at the ADH center, the client may receive one (l) pack of frozen meals per week, which equals to seven (7) meals. If the client attends the center less than five (5) days a week, the Case Manager should make sound judgement as to whether the client is eligible for the service.

   Based on established need, some clients may get home delivered hot meals (provided outside the waiver program) and waiver meals. This is to be an exception and not the norm and as such, approved on a case by case basis depending upon the level of care need. There must be a clear audit trail, which clearly defines how many meals the client receives.

3. Standard Diets

a. Menus must comply with the most recent Dietary Guidelines for Americans, published by the Secretary of Health and Human Services and the Secretary of Agriculture.

b. Each meal in a pack of frozen meals must provide a minimum of 700 kilocalories. The mean level of the indicator nutrients per frozen meal in a pack of frozen meals must be equal to or higher than one-third (1/3) of the Dietary Reference Intake (DRI) for adults as determined by the Food and Nutrition Board of the Institute of Medicine of the National Academy of Sciences. Home Delivered Meals service will not constitute a full daily nutritional regimen.

c. Menus for breakfast meals must be matched to menus for frozen meals. The mean level of the indicator nutrients provided in a pack of frozen meals and a pack of breakfast meals must equal or exceed 2/3 of the DRI for adults.

d. While the individual has freedom of choice regarding this service, it is the responsibility of the Case Manager to ensure the appropriateness of the service and to ensure the client qualifies for the service. All clients eligible for this service must be given free choice of all qualified providers.

If, after careful review of the assessment information and discussion of the client's situation, the Case Manager does not think the Home Delivered Meals are appropriate for the individual, (or there are risks to the client associated with the meals), other options that will assist in meeting the nutritional needs of the client should be discussed with the client and documented in the case record. Should the client insist on the meals, providing they meet the other qualifying criteria, additional information should be secured from the physician. In the event the client continues to insist on meals against the Case Manager's and Physician's advice, the client has a right to make this choice. Documentation of the risk being taken by the client must be documented in the case record and discussed in detail with the client, responsible relative or friend, if available, and the physician.

4. <u>Menu Requirements for Emergency Meals</u>

a. Shelf-stable meals will be delivered at least every six (6) months to at-risk clients. Shelf-stable meals are to be used in the event of an emergency when the DSP cannot deliver meals as scheduled. The number of units will be determined by the client's plan of care, not to exceed six (6) meals per 6-month period.

b. All foods in the meal must be individually packaged food products that can be stored without refrigeration and that can be eaten with little or no preparation. The meal must provide a minimum of 700 kilocalories and one-third (1/3) of the DRI for the indicator nutrients for adults. Sodium content of the meals may be somewhat high because of the necessary reliance on commercially formulated food products.

c. Shelf-stable meals are intended for use solely in emergency situations.

d. During times of the year when the state is at an increased risk of disaster from hurricanes, tornados or ice/snow conditions, the meals vendor will be required to maintain at a minimum, a sufficient inventory to operate all frozen meal delivery routes for two (2) days. In the event of an expected storm or disaster, the Meals Coordinator will authorize implementation of a Medicaid–approved Disaster Meal Services Plan. This plan (outlined in "F") will provide frozen meal alternatives in anticipation of possible power outages.

5. All menus must be reviewed and approved by the Meals Services Coordinator, who is a Registered Dietitian licensed to practice in the State of Alabama and employed by the OA.

6. The DSP will provide a list of its regularly scheduled holidays to the OA, and the DSP will not be required to deliver meals on those days. The DSP Agency must not be closed for more than four (4) consecutive days at a time and then only if a holiday falls in conjunction with a weekend. The DSP will also provide the regular hours of business operation. Arrangements should be made by the DSP to see that clients do not go without a meal as a result of the holiday schedule.

7. The DSP must provide meals 52 weeks a year. During holiday periods, meal delivery schedules may be adjusted per agreement between the OA and the DSP. When the delivery schedule must be altered due to a holiday, the DSP must bill the services for the date of the regularly scheduled delivery, as long as there is documentation that the delivery occurred prior to the bill date.

8. <u>Service Standards</u>

a. Each DSP must provide one (1) frozen meal per day, seven (7) days per week for 52 weeks per year, and any additional authorized meals.

b. The facility at which the meals are prepared and/or packaged, as well as the manner of handling, transporting, serving and delivery of these meals, must meet all applicable health, fire, safety and sanitation regulations.

c. No home canned or prepared food shall be used in preparation and service of the meals.

d. Primary meal components of frozen meals (entree plus two side dishes) must be produced at a food processing plant with United States Department of Agriculture (USDA) approval or its equivalent in the state of Alabama. The DSP will furnish the OA with copy of said USDA approval or its equivalent in the state of Alabama to produce meals for the frozen meal program. Products must be quick frozen in a blast freezer or the equivalent.

e. Primary meal components shall be packaged in individual trays, properly sealed, and labeled with the contents and instruction for storage and preparation. Each meal is stamped with the "best by" date and the "produced" date .

f. Primary meal components of frozen meals (entree plus two side dishes) must be packaged as single meal units in a container that is suitable for re-thermalization in a microwave or conventional oven at temperatures up to 400° F.

g. The DSP will be responsible for meal delivery to the client.

(1) Delivery routes must be clearly established. Meal packs must be delivered once weekly on days mutually agreed upon by the DSP and the OA. Clients will be informed of the delivery date and projected delivery time. The DSP must deliver meals within plus or minus two hours of projected delivery time and deliver all meal components to a client in a single stop.

(2) Cold food will be individually portioned. The only exception is that milk will be delivered in one half-gallon container for every service unit of frozen meals and breakfast meals. Cold food will be transported in approved insulated carriers which will maintain the required cold (41 degrees Fahrenheit or below) temperatures until the time of delivery to the client. Frozen meals must be transported in approved insulated carriers that will maintain the meals in a solid frozen state until the time of delivery to the client. Alternatively, a frozen meal delivery truck may be used to transport and deliver meals.

(3) Meal delivery must be documented with a signed delivery ticket. The client, family, friend, or neighbor must sign verifying that the meals were received or other mutually agreed upon electronic means of verification. Meals may not under any circumstance be left at a home if the intended client or the designated representative (family member, friend, or neighbor) is not available to receive them. In the situation where the client is blind and unable to sign for the delivery, it is the case manager's responsibility to document that fact in a manner agreed upon by the OA and the DSP. In the event of extenuating circumstances where the client cannot sign, the DSP personnel must make a note in the signature area and initial that information.

(4) The DSP will be responsible for notifying the client and the case manager in the event of a change in the delivery day or projected delivery time. Because of the logistics involved in notifying all clients of a change in the delivery day, modification of the delivery day must be a last resort.

(5) Home Delivered Meals are provided for the benefit of the client and to

meet client needs rather than others in the client's household.

D. Provider Certification Requirements

1. The DSP shall give initial and on-going training in the proper service, handling, and delivery of food to all staff. Proof of the training must be recorded in the personnel file.

2. The DSP must comply with all applicable statues, regulations, guidelines and policies at the local, State, and Federal levels including, but not limited to:

   a. Food purchasing; food preparation and processing; food packaging and labeling; food storage, transport, and service; food safety; and food sanitation.

   b. Equal Opportunity, Civil Rights, Affirmative Action, and Age Discrimination.

   c. Fire and safety codes for both equipment and employees.

   d. Use of Federal and State funds.

   e. Client rights and confidentiality.

3. The DSP will procure and keep current any license, certification, permit, or accreditation required by local, State, or Federal statues or regulations and shall, upon request of the OA, submit proof of any such license, certification, permit or accreditation.

4. The DSP will have verified references on each employee in direct contact with recipients and recipient information maintained in the employee personnel file. References must include statewide criminal background checks (including sex offender registry), previous employers, and the Nurse Aide Registry (if applicable).

E. Procedure of Services

1. The DSP will initiate Home Delivered Meals on the date negotiated with the Case Manager and indicated on the Service Authorization Form. Services must not be provided prior to the authorized start date as stated on the Service Authorization Form.

   a. The Case Manager will provide the DSP with the name, telephone number, address, driving directions, and an alternate contact for each client. Information will be sent to the DSP electronically.

b. Requests for adding up to five (5) new clients to an established delivery route should normally be accommodated by the DSP on the next scheduled delivery or within fourteen (14) calendar days if service is established by cut off time each week.

c. Requests for major increases in clients, especially if it requires establishment of new delivery route(s), may require up to three (3) weeks advance written notice to the DSP.

2. Missed and Attempted Deliveries

a. A missed delivery occurs when the client or the person designated to receive the delivery is at the client's residence waiting for the meal delivery and the delivery is not made. In the event of a missed delivery, the DSP will advise the Case Manager by phone or electronically of the non-delivery of the meal pack. Notification must occur no later than the next business day of the non delivery. The DSP must have an effective back-up service provision plan in place to ensure that the client receives the meals as authorized.

b. An attempted delivery occurs when the meals could not be delivered to a client because the client or designated representative was not available to accept delivery. In the event of an attempted delivery, the DSP will advise the Case Manager by phone or electronically of the non-delivery of the meal pack. Notification must occur within 24 hours of the non-delivery. The Case Manager will be responsible for client follow-up and arranging emergency meals for at-risk clients.

c. The DSP may not bill for missed or attempted deliveries. If meals distributed to clients are later learned to be lacking components or to have contained components of unacceptable quality, payment to the DSP will be adjusted according to a schedule mutually agreed upon by the DSP and the OA.

d. The Case Manager will be responsible for instructing each client, both verbally and in writing concerning the storage and preparation of the frozen and breakfast meals. This will also include written re-thermalization instructions.

e. If a client goes to the hospital or nursing home for a temporary stay and meals for this time period have been delivered, the Case Manager would be responsible for determining the date meal delivery should resume based on the number of complete meals still available to the client for consumption. If the temporary absence is anticipated, the meals can be suspended in advance.

3. The DSP will notify the Case Manager electronically within three (3) working days of the following client changes:

   a. Client's condition has changed and the Plan of Care no longer meets the client's needs or client no longer appears to need home delivered meal services.

   b. Client dies or moves out of service area.

   c. Client no longer wishes to participate in Home Delivered Meal Service.

   d. Knowledge of the client's Medicaid ineligibility or potential ineligibility.

   e. When services can no longer be provided.

4. The Case Manager will review a client's service plan within one (1) working day of receipt of a request from the DSP to modify service plan.

5. The DSP will maintain an electronic record keeping system that establishes an eligible client profile, in support of units of Home Delivered Meal Service provided, based on the Service Authorization Form.

6. The Case Manager will request Home Delivered Meal Services by designating the type meal, amount, frequency and duration of service for clients in accordance with the client's Plan of Care developed in consultation with the client. More than one meal for each day's consumption may be delivered if authorized by the client's Plan of Care. Requests for services will be transmitted electronically.

7. The OA will send notice electronically to the DSP immediately (within 24 hours of discovery) if a client becomes ineligible for services. The DSP will be responsible for terminating all further services upon receipt of notification.

8. The DSP must be able to provide meal delivery services in the designated service area within 60 days after a new service contract is signed. Service contracts may be canceled by either the DSP or the OA, with or without cause. Contracts may be canceled by the DSP by giving the OA not less than 90 days written notice of intent to terminate services as of a specified date. Contracts may be canceled by the OA by giving the DSP not less than 30 days written notice of intent to terminate services as of a specified date.

9. The OA will employ a licensed Registered Dietitian licensed to practice in the State of Alabama to serve as Meals Services Coordinator. This individual will review and approve all menus, all food product specifications, all packaging materials and procedures, and delivery operations; provide nutritional oversight and monitoring, consultation and training assistance to the OA; and perform quality assurance activities.

10. Written instructions for distribution to clients regarding the use of the meals will be developed by the Meals Services Coordinator. Written and verbal instructions will be provided by the Case Manager to the client/responsible person prior to the start of service. The Case Manager will monitor use of the meals.

F. Meal Services During a Disaster

1) During hurricane season (June-November), vendor production units serving the southern region of the state will maintain, at a minimum, sufficient inventory of the items listed below to operate all frozen meals delivery routes for two (2) days. During the ice/snow/tornado season (December-May), vendor production units serving the northern region of the state will maintain, at a minimum, sufficient inventory of the items listed below to operate all frozen meals delivery routes for two (2) days. In such emergency situations, production units will shift inventories to areas of need.

   a) Shelf stable meals packed 7 per box**.** Provided in lieu of frozen meals. Delivered 1 per client for all persons authorized to receive 1 service unit of frozen meals and 2 per client for all persons authorized to receive 2 service units of frozen meals.
   b) Water packed in gallon size units. Provided in lieu of ½-gallon fresh milk. Delivered 1 per client for all persons authorized to receive 1 service unit of frozen meals and 2 per client for all persons authorized to receive 2 service units of frozen meals.
   c) Breakfast meals packed 7 per box. Packed as designated for regular menu. Delivered 1 per client for all persons authorized to receive 1 service unit of breakfast meals.
   d) Non-fat dry milk individual packets. Provided in lieu of ½ gallon fresh milk. Delivered 7 per client for all persons authorized to receive 1 service unit of breakfast meals.
   e) Cereal Grain Breakfast Bars. Provided in lieu of 2 pints orange juice. Delivered 7 per client for all persons authorized to receive 1 service unit of breakfast meals.

2) The combination of shelf-stable meals packed 7 per box/1 gallon of water will hereafter be referred to as frozen meal alternates. The combination of breakfast meals packed 7 per box/7 individual portions of non-fat dry milk/7 cereal grain breakfast bars will hereafter be referred to as breakfast meal alternates.

3) Meals Coordinator may authorize delivery of frozen meal alternates and breakfast meal alternates for up to two (2) days prior to an expected storm/disaster.

4) With authorization of the Meals Coordinator, modified disaster deliveries may be made after a storm/disaster until the ability to store and prepare frozen or breakfast meals is restored in the client's home. At times, it is likely that deliveries will be mixed on a route. Some clients will continue to need disaster meals, but others may resume regular meal deliveries.

The vendor will supply units of frozen and breakfast meal alternatives to the production units as required to sustain service. Menus for breakfast meals delivered to production units after a major storm/disaster may be modified to eliminate any cream cheese and margarine.

5) Prior to an expected storm, production units in the projected path will print out driver manifests for the next 3-day period. These manifests reflect the standing orders for the clients.

6) As required to reduce or rotate inventory of shelf-stable meals, Meals Coordinator may authorize the vendor to provide frozen meal alternates in lieu of frozen meals to clients affected by a holiday closing. All clients scheduled to receive a meal delivery on one of the official vendor holidays may receive a double delivery of frozen meals the preceding week. Shelf-stable meals packed 7 per box and 1 gallon of water may replace no more than one (1) service unit of frozen meals for a client in a double delivery. All clients affected by a holiday closing will be provided with a letter two weeks before the holiday alerting them to the double delivery and the mix of meals that will be delivered. The vendor will be responsible for delivery of the letter.

7) Costs for a 7 pack of shelf stable meals plus 1 gallon of water (frozen meal alternate) will be the same as for a 7 pack of frozen meals plus ½ gallon of fresh milk. Costs for a 7 pack of breakfast meals, 7 packages of non-fat dry milk and 7 breakfast bars (breakfast meal alternate) will be the same as for a 7 pack of breakfast meals plus ½ gallon fresh milk and 2 pints orange juice.

8) When the Meals Coordinator authorizes implementation of this plan, notice will be sent to the appropriate staff at Medicaid, Department of Public Health, and Department of Senior Services. No specific documentation will be required in the client's operating agency case record to justify or authorize billing for meal alternatives delivered according to this plan.

When frozen or breakfast meal alternates are delivered (i.e. prior to or after a storm/disaster or on holidays), drivers will be instructed to note on the manifest any deviations from the standing client orders (i.e., frozen meal alternate delivered in lieu of frozen meals; breakfast meal alternate delivered in lieu of breakfast meals). Vendor will retain said manifests and provide copies to Case Manager(s) or the appropriate operating agency or Medicaid upon request.

The same billing code will be used for the 7-pack frozen meals and the 7-pack frozen meal alternates. Likewise, the same billing code will be used for the 7-pack breakfast meals and the 7-pack breakfast meal alternates. However, the invoice sent to the operating agencies will show the number of 7-pack frozen meals, the number of 7-pack frozen meal alternates, the number of breakfast meals, and the number of breakfast meal alternates delivered during the invoice period.

G. Rights, Responsibilities, and Service Complaints

1. The OA has the responsibility of ensuring that the DSP has fulfilled its duty of properly informing the client of all rights and responsibilities and the manner in which service complaints may be registered.

2. The DSP Agency will inform the client/responsible party of their right to lodge a complaint about the quality of Home Delivered Meal Service provided and will provide information about how to register a complaint with the Case Manager as well as the Alabama Medicaid Agency (AMA).

   a. Complaints which are made regarding the meals or DSP staff will be investigated by the Case Manager and reported to the Meals Services Coordinator for each operating agency. The Meals Services Coordinator will perform an investigation. All corrective action by the Case Manager or the Meals Service Coordinator will be documented and forwarded to the Waiver Coordinator of the OA.

   b. The DSP will have procedures for the investigation and resolution of complaints.

3. The DSP must maintain documentation of all complaints, follow-up, and corrective action regarding the investigation of those complaints and documentation showing that they have completed with the requirements of this section.

H. Administrative Requirements

In addition to all conditions and requirements contained in the Scope of Services as well as in the contract, the DSP shall be required to adhere to the following stipulations:

1. The DSP Agency shall designate an individual to serve as the agency administrator who shall employ qualified personnel and ensure adequate staff education, in-services training and perform employee evaluations. This does not have to be a full time position; however, the designated administrator must have the authority and responsibility for the direction of the DSP Agency. The DSP Agency shall notify the OA within three (3) working days of a change in the agency administrator, address, phone number or an extended absence of the

agency administrator.

2. The DSP will maintain an organizational chart indicating the administrative control and lines of authority for the delegation of responsibility down to the "hands on" client care level staff shall be set forth in writing. This information will be readily accessible to all staff. A copy of this information shall be forwarded to the OA at the time the contract is implemented. Any future revisions or modifications shall be distributed to all staff of the DSP Agency and the OA.

3. Administrative and supervisory functions shall not be delegated to another agency or organization.

4. A list of the members of the DSP's governing body shall be made available to the OA and/or the AMA upon request.

5. The DSP Agency must maintain an annual operating budget which shall be made available to the OA and/or the AMA upon request.

6. During the life of the contract the DSP Agency shall acquire and maintain liability insurance to protect all paid and volunteer staff, including board members, from liability incurred while acting on behalf of the agency. Upon request, the DSP Agency shall furnish a copy of the insurance policy to the OA and/or the AMA.

7. The DSP Agency shall ensure that key agency staff, including the agency administrator or the DSP Supervisor, be present during compliance review audits conducted by Medicaid, the OA and/or its agents.

8. The DSP Agency shall maintain an office which is open during normal business hours and staffed with qualified personnel.

9. The Direct Service Provider (DSP) shall provide its regularly scheduled holidays to the OA. The DSP Agency must not be closed for more than four (4) consecutive days at a time and then only if a holiday falls in conjunction with a weekend. The DSP shall also provide the regular hours of business operation. If a service is needed on a scheduled holiday, the service provider will ensure that the service is rendered.

10. The DSP Agency will maintain a Policy and Procedures Manual to describe how activities will be performed in accordance with the terms of the OA contract and Waiver Document. The Policy and Procedure Manual should include the Organization's Emergency Plan regarding service delivery.

11. A performance bond will be required of the DSP in the amount equal to the projected cost of one year's services provided by said DSP.

I. Provider Experience

Providers of Home Delivered Meals must meet all provider qualification requirements prior to furnishing Home Delivered Meals.

All personnel with direct client contact or access to client information must have complete reference verification and statewide criminal background checks on file prior to client contact or access to client information.

CHAPTER 8

PROVIDERS

A. CONDITION FOR PARTICIPATION

1. Definition of Agency

   a. To participate in the HCBS EDW program, a provider of service shall meet the licensure and certification requirements as outlined in the waiver document. On-site reviews of each service provider shall be conducted initially and biannually thereafter, unless otherwise specified in the waiver document. The participating service providers shall furnish services under contractual arrangement with the AMA and the OA.

      Clients shall not be placed on waiting lists for services which the provider of direct in-home services cannot deliver.

   b. Agreements made by the OA with direct service providers shall be in writing. These agreements shall stipulate that receipt of payment by the OA for the service (whether in its own right or as an agent) relieves any liability on the part of the Medicaid client to make any additional payment.

   c. Providers have the right to limit the number of Medicaid recipients they are willing to serve; however, providers may not discriminate in selecting the Medicaid recipients they will serve.

2. Record Requirement

   a. The CM and OA shall be required to maintain for each recipient clinical records which cover the waiver services provided and nonwaiver services provided by other direct service providers. These records must contain pertinent, past and current medical, nursing, social and other information including the comprehensive assessment and the plan of care. Signature stamps on documents are unacceptable.

   b. The OA and the provider of direct service shall furnish any required requested information to the AMA.

   c. All information on EDW program applicants and recipients, including those persons referred to the EDW program shall be safeguarded in accordance with the provisions of the Code of Federal Regulations governing confidentiality (CFR 42 431.305).

      (1) Confidential information includes but is not limited to:

(a) The name and address of the individual served and the service they received;

(b) Medical data, including diagnosis and past history of disease or disability;

(c) Agency evaluation of information about a person;

(d) The identity of persons or institutions that furnished health services to a person;

(e) The social and economic conditions or circumstances of any person served; and

(f) Federal program information identified as confidential by appropriate federal authority.

d. All OA personnel, direct service provider personnel, persons receiving services through the EDW services and all other persons dealing with EDW service shall be informed of the agency's policies and regulations with respect to safeguarding of confidential information.

B. FINANCIAL ACCOUNTABILITY OF PROVIDERS

1. The financial accountability of providers for funds spent on HCBS must maintain a clearly defined audit trail. Providers must keep records that fully show the extent and cost of services provided to eligible clients for a five year period. These records must be accessible to the AMA and the appropriate state and federal officials. If these records are not available within the state of Alabama, the provider will pay the travel cost of the auditors to the location of the records.

2. The providers of this waiver will have their financial records audited at least annually at the discretion of the AMA. Payments are adjusted to actual cost and if there is an underpayment found payment would be made. If an overpayment is found, the AMA will recover funds.

3. The AMA will review at least annually, a sample of clients and services provided through the EDW. The review will include the appropriateness of care provided and proper billing procedures.

4. The OA's of the EDW will provide documentation of actual costs of services and administration. Such documentation will be entitled "Quarterly Cost Reports for the EDW". The Quarterly Cost report will include all actual costs incurred by the OA for the previous quarter and costs incurred year to date.

5. This document will be sent to the AMA before the 1st day of the third month of the next quarter.

a.	1st October - December	Due before March 1st
b.	2nd January - March	Due before June 1st
c.	3rd April - July	Due before October 1st
d.	4th August - October	Due before January 1st

6. Failure to submit the actual cost documentation may result in the AMA deferring payment until this documentation has been received and reviewed.

C. AUDITING STANDARDS

1. Office of Management and Budget (OMB) Circular A-87, "Cost Principles for State and Local Governments" will apply to governmental agencies participating in this program. For nongovernmental agencies, accepted accounting principles will apply. Governmental and nongovernmental agencies will use the accrual method of accounting unless otherwise authorized by the AMA.

D. ALLOWABLE, UNALLOWABLE COSTS

1. 45 CFR part 95, specifies dollar limits and accounting principles for the purchase of equipment. Purchases above the $2500 limit require the approval of Medicaid.

2. OMB Circular A-87 establishes cost principles for governmental agencies and will serve as a guide for nongovernmental agencies. For governmental agencies all reported costs will be adjusted to cost at the end of the year.

3. Contract payments for the delivery of specific services are allowable expenses. Thus, contracts for home and community-based waiver services are recognized expenses. All other contracts will require Medicaid approval to insure that functions are not being duplicated. For example, outreach is to be performed by the case manager; thus, it would not be proper to approve other contracts for outreach unless it can be clearly shown that the function is needed and cannot be provided within the established organization.

4. Allowable Costs

a. Allowable costs are defined in the OMB Circular A-87. However, the following restrictions apply:

(1) Advertisement is recognized only for recruitment of personnel, solicitation of bids for services of goods, and disposal of scrap

surplus. The cost must be reasonable and appropriate.

(2) The cost of buildings and equipment is recognized. For governmental agencies, buildings and equipment exceeding $25,000 will be capitalized in accordance with 45 CFR 95.705 and depreciated through a use allowance of 2 percent of acquisition cost for building and 6⅔ percent for equipment, see 45 CFR 95.641. When approval is required, the request will be submitted to the AMA in writing.

(3) The acquisition of transportation equipment will require prior approval from the AMA. When approval is required, the request will be made to the AMA in writing.

(4) Transportation is an allowable expense to be reimbursed as follows:

(a) For nongovernmental agencies, it will be considered as part of the contract rate.

(b) For government and private automobiles utilized by state employees, reimbursement will be no more than the current approved state rate.

(c) All other types transportation cost will be supported by documents authorizing the travel and validating the payment.

5. Unallowable Costs

a. The cost of advisory councils or consultants without AMA's approval.

b. Legal fees are as follows:

(1) Retainers,

(2) Relating to fair hearings,

(3) In connection with lawsuits which result in an adverse decision,

(4) Services that duplicate functions performed by Medicaid or the provider such as eligibility determination for the program,

(5) Other legal fees not relating to providing services to the beneficiaries, and

(6) Dues and subscriptions not related to the specific services.

E. COST ALLOCATION PLANS

1. State agencies must have a cost allocation plan approved by the Division of Cost Allocation (DCA) when the agencies handle multiple federal funds. The format of a cost allocation plan is specified by 45 CFR 95.507, which also calls for written agreements between state agencies. Existence of such a plan will be an item of audit.

2. Direct costs are charged to the specific services that incurred them. It is the indirect/overhead costs that are allocated to the specific fund. If there is more than one project within a fund, there must be a plan in writing to distribute the cost among the projects. There are two types of indirect costs:

   - The first are those that can be associated with the services that are provided, such as an assessment at the central office that verifies the quality of service.

   - This cost can be prorated to each service by some method that is described in writing. This first type of cost qualifies for the federal match benefit percentage.

   - The second type of allocated cost falls under the administration definition. For example, a case manager that spends time on two individuals (or group of people) that have not attained waiver eligibility. This second type has a federal match of 50/50; therefore, both types must be accounted for separately.

3. Contracts, which are used for buying services from other governmental agencies, must be cost-allocated. As a minimum, these contracts should meet the requirement of 45 CFR 95.507. These contracts must show:

   a. The specific services being purchased,

   b. The basis upon which the billing will be made, i.e., time reports, number of homes inspected, etc.,

   c. A stipulation that the billing will be based on actual costs incurred. This is not a requirement for nongovernmental agencies. For governmental agencies, the billing should be either actual cost or an agreed upon fixed fee approximating actual cost which will be adjusted to actual cost at completion of the fiscal year.

CHAPTER 9

LONG TERM CARE WAIVER

Quality Assurance Manual

ELDERLY & DISABLED WAIVER

SAIL WAIVER

530 (HIV/AIDS) WAIVER

MR WAIVER

LIVING AT HOME WAIVER

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MISSION STATEMENT

The mission of the Alabama Medicaid Agency's (AMA) Long Term Care (LTC) Waiver Quality Assurance (QA) Program is to assure that waiver participants receive quality care in the home and community setting. This mission is designed to assure:

- Quality of care pertaining to preventing abuse and neglect
- Access to services and needs of waiver participants are met
- Participants are allowed to participate in the care planning process.
- Participants health and welfare is not jeopardized

This mission is multi-faceted, based upon a planned, systematic, and ongoing process for monitoring, evaluating, and improving the quality and appropriateness of care provided to individuals receiving Home and Community Based Waiver Services.

THE MONITORING PROCESS

The monitoring process is designed to ensure the Operating Agencies (OA) and the Direct Service Providers (DSP) compliance with the approved 1915(c) Home and Community Based Waiver document, contractual agreements, state and federal health care guidelines, and applicable federal and state regulations governing quality assurance and utilization management. The monitoring process is also designed to identify patterns or trends of care and the sentinel effects of the process that warrant further evaluation.

EVALUATION PROCESS

The evaluation process is designed to determine the presence or absence of an opportunity to improve access to waiver services, to assure the health and safety of waiver participants, and to assure the quality and/or appropriateness of care.

AMA QUALITY ASSURANCE STAFF

Medicaid's Waiver Quality Assurance Program is located on the AMA organizational chart under the Medicaid Director of the Long Term Care Division. Quality assurance activities are directed by:

- A registered nurse administrator with a Degree in Nursing or related field and
- A current license to practice nursing in the State of Alabama.

Quality Assurance Reviews are conducted by:

- A registered nurse with a nursing diploma/certification or degree from an approved school of nursing and
- A current license to practice nursing in the state of Alabama.

PURPOSE OF QUALITY ASSURANCE

The purpose of the LTC Waiver Quality Assurance Program is to organize and provide direction for quality assurance activities for the Home and Community Based Waiver programs. The primary focus is to:

- Improve the quality of community care
- Assure that the participants health and safety needs are met
- Assure that appropriate care is provided
- Assure that the providers of services meet the provider qualifications specified in the approved waiver.

PROCESS

The LTC Waiver Quality Assurance process is a coordinated, comprehensive and ongoing process that monitors and evaluates the implementation and ongoing utilization of the Home and Community Based Waiver Programs. Quality assurance activities are conducted to assure that AMA, the OA and the DSP comply with the requirements of the Home and Community Based Waiver documents.

KEY COMPONENTS ASSOCIATED WITH THIS PROCESS INCLUDE THE EVALUATION OF:

- Health and welfare of waiver participants
- Responsiveness of the POC to the participant's needs
- Qualifications of providers who serve waiver participants
- Appropriateness of services to the participant's needs
- Freedom of choice being offered to participants
- Quality improvements activities
- Client satisfaction indicators
- Complaint and grievance process
- Accessibility to waiver services
- Access to other available community care options
- Continuity of care.

KEY TERMS ASSOCIATED WITH THIS PROCESS INCLUDE:

- Access to Care: Assurance of available and appropriate health care services to all participants
- Appeal: Any appeal is a special kind of complaint used if the participant disagrees with a decision to deny a request for health care services or payment for services already received.
- Appropriateness of Service: Assurance of appropriate waiver services for each waiver participant based upon individual needs
- Client Satisfaction Survey: Survey assessing the quality of care received by waiver participants
- Complaints**:** See Grievance
- Direct Service Provider: A provider that contracts with the OA to provide direct service (i.e., personal, homemaker, adult day health, respite) to the waiver recipient
- Deficiency: Service(s) required by the waiver document but not identified as having been implemented by the OA and/or service provider during the QA review
- Freedom of Choice: Assurance that the participant exercises the right to choose the type of service needed and the provider of service and home and community based services or institutionalization.
- *Due Process: The process which allows the participant an opportunity to appeal an adverse decision*
- *Grievance**:** Any complaint or dispute, oral or written expressing dissatisfaction with the following: availability, delivery, quality of care, payment, treatment, reimbursement for services. It is not the way to deal with a complaint about a treatment decision or a service that is not covered. (See Appeal)*
- *Plan of Care: Plan that identifies all services the waiver participants receives and the frequency of the service*
- Operating Agency: State agencies that contract with the AMA to provide the services within the waiver program

- Quality Improvement Activities: Periodic review of quality assurance policies and procedures with revisions implemented when necessary.

AMA WORK PLAN
FOR QUALITY ASSURANCE REVIEWS

OVERVIEW

MONITORING QUALITY ASSURANCE OF THE HOME AND COMMUNITY BASED WAIVERS

Quality Assurance (QA) as defined by the AMA Home and Community Based Waiver Program is the process of monitoring and evaluating the delivery of community care to ensure that services rendered are appropriate, timely, accessible, available and, medically necessary. The services should safeguard the health and welfare of the participants as well as prevent institutionalization.

GENERAL OBJECTIVES OF QUALITY ASSURANCE

- To determine the effectiveness of the HCBS Waiver Quality Assurance Program
- To assure waiver participants have access to waiver services through the process of monitoring quality assurance procedures
- To assure waiver participants are able to exercise the right of freedom of choice of waiver services and providers, and to choose between home and community based services and institutionalization.
- To assure the health and welfare of waiver participants, and to identify, address, and prevent abuse, neglect and exploitation of individuals served by the waiver
- To assure waiver participants are receiving services identified in the plan of care by qualified personnel through monitoring a sample of recipient records and personnel records

- To assure implementation and ongoing utilization of quality assurance standards of the OA, the AMA, and the Center for Medicare and Medicaid Services (CMS) through evaluation of the organizational structures of direct service providers, and reports of quality assurance activities.

These objectives will be met by conducting an annual review of each OA. AMA Review Coordinators will conduct the review, and the following elements will be evaluated:

- A sample of Recipient records will be reviewed to ensure:
    1. Level of care and admission criteria are met
    2. Plan of care is appropriate
    3. Freedom of choice
    4. Patient rights
    5. Services reimbursed by Medicaid were provided.
- OA policies, procedures, organizational structure and staff qualifications will be reviewed to ensure the OA is operating in accordance with waiver guidelines.
- OA documentation of contractual agreements between the OA and the DSP will be reviewed to ensure that qualified providers are rendering services to Medicaid waiver recipients.
- OA documentation of QA visits to DSP will be reviewed to ensure:
    1. OA is conducting QA reviews
    2. DSP is providing services in accordance with waiver guidelines.
- OA complaint and grievance procedures will be reviewed to ensure:
    1. A process is in place in accordance with Medicaid waiver guidelines
    2. Complaints/grievances are tracked through to resolution
    3. Adverse findings are reported to the appropriate authority for final determination
    4. Health and safety of the client is not at risk
    5. An appeals process is in place in accordance with waiver guidelines.
- Visits to client homes may be done to determine:
    1. Effectiveness of service provision
    2. Appropriateness of services
    3. Adequacy of equipment and supplies
    4. Accessibility of general condition of home
    5. Safety of home and equipment.
    6. Participant satisfaction

AMA INTERNAL QUALITY ASSURANCE PLAN

The AMA will maintain an internal Quality Assurance Program that meets the requirements of 1902 (a), 1915 (c) of the Social Security Act, 42 CFR 440.260, 441.302-441.303, and in accordance with the Home and Community Based Waiver documents.

OBJECTIVES:

- To assure consistency with federal and state regulations and guidelines
- To assure quality oversight and review of quality assurance activities by appropriate professionals
- To assure a systematic way of collecting and analyzing data as it relates to quality assurance activities
- To assure formal and systematic ways to monitor access to care and to assess quality care
- To assure the health, welfare and safety of waiver participants
- To assure that complaints and grievance procedures are in compliance with federal and state regulations and that complaints and grievances are tracked through resolution.

These objectives will be met using the following procedures:

- The AMA LTC Program Manager and the LTC Waiver QA Unit will meet periodically to review quality assurance policy and procedures and to make revisions as needed.
- Periodically meetings with the OA will be conducted to disseminate information about Medicaid and waiver-specific requirements; identify quality assurance issues; problem DSP and identify trends and patterns in service delivery
- Onsite reviews will be performed to ensure OA and DSP compliance with the waiver document
- Annual review of the OA written policies and procedures will be performed. LTC Waiver QA will review this information during the annual onsite OA audit.
- Satisfaction Surveys will be mailed to a representative sample of the waiver participants/representative to determine the benefits and effects of the program
- Investigate complaints/grievances received by the Waiver QA Program until full resolution. The complaint and grievance log and documentation of efforts to resolve the issue will be kept on file in the LTC Waiver QA program; a copy will be forwarded to LTC Program Manager
- Tracking of complaints/grievances will be ongoing. The OA will make all the complaints/grievances available to the AMA quarterly. The OA will report complaints/ grievances on the Compliant/Grievance Log and the Log will be forward to AMA LTC Waiver QA Program no more than 10 days after the end of each quarter. The LTC Waiver QA Program will review the information to ensure appropriate resolution of legitimate complaints/grievances and mail targeted surveys to participants to assure complaints have been resolve to their satisfaction.

ROLE AND FUNCTION OF THE OA IN THE IMPLEMENTATION OF QA POLICIES AND PROCEDURES

Each OA will have in place a QA system that meets the guidelines as outlined in the AMA Internal QA Plan.

OBJECTIVES:

- To assure appropriate oversight and review of quality assurance activities
- To assure a formal and systematic way to monitor access to care and to assess quality care

- To identify patterns and trends in the provision of care that warrant further evaluation
- To determine the presence or absence of opportunities to improve delivery of quality care
- To assure the health, welfare and safety of waiver participants
- To assure that complaint/grievance procedures are in compliance with federal and state regulations and that complaints/grievances are tracked through to resolution.

These objectives will be met using the following procedures:

- The OA will have a system in place to assure quality review of case management records on an ongoing basis. This system will be designed to assess the quality and appropriateness of care; clients are given freedom of choice of providers and services; and that clients are given the right to voice complaints and to appeal an adverse decision
- The OA will have a system in place to assure quality review of DSP. This system will be designed to ensure services are rendered as authorized and in accordance with state and federal regulation. To ensure that services are being rendered in a safe and appropriate manner that will not jeopardize the health and safety of the waiver participant and; to ensure waiver participants have been informed of the right to voice a complaint and appeal decisions regarding care provided through the waiver program.

REVIEW OF THE OA QUALITY ASSURANCE SYSTEM

The AMA Review Coordinators will review the OA Quality Assurance system for evidence that the OA has implemented its QA policies and procedures and to ensure that these policies and procedures are revised as needed.

The scope of review of the OA will require review of written policies and procedures, and written reports.

Review findings will be submitted to the OA, AMA LTC Program Manager, and a copy will be maintained by AMA LTC Waiver Quality Assurance Program. Upon request, findings will be submitted to the Secretary of HHS, the Inspector General, and CMS.

OBJECTIVES:

- To assure consistency with Federal and State rules regulations, and guidelines
- To assure QA policies and procedures are in effect
- To assure ongoing QA activity
- To assure that a contingency plan for emergencies as well as ensure that mechanisms are in place for back-up care when usual care is unavailable
- To assure that complaint/grievance procedures are in place.

These objectives will be met using the following procedures:

- Annual review of the OA's QA policies and procedures to ensure that they are in place

- Review written document to ensure the OA will revise the QA plan in response to QA activities
- Review written documents to ensure contingency plans and back up care is available
- Review the OA complaints/grievances to ensure they are tracked through to resolution.
- Review of the OA contracts with new DSP to ensure that requirements of the waiver are met prior to enrollment.
- Review of initial and ongoing training to DSP to ensure that OA is providing required training.

REVIEW OF CASE MANAGEMENT SOURCE

The AMA Review Coordinators will conduct quality assurance reviews of case management records to evaluate the quality of services furnished by the OA through case management source.

The scope of the review will require claims validation through random sampling of records to determine consistency with billing documented on recipient data sheets; review of employee personnel records to ensure consistency with minimum and continued educational requirements; review of facilities and/or participant's homes to ensure health and safety of waiver participants; and to gather input and feedback from the waiver participants and or their family.

Review findings will be submitted to the OA, AMA LTC Program Manager and a copy will be maintained by AMA LTC Waiver Quality Assurance Program. Upon request, finding will be submitted to the Secretary of HHS, the Inspector General, and CMS.

OBJECTIVES:

- To assure consistency with federal and state rules regulations, and guidelines
- To validate claims data and other information submitted to the AMA
- To assure waiver participants are receiving services identified in the plan of care
- To assure appropriateness of care and services provided to waiver participants
- To assure services are provided by qualified personnel
- To assure the health, welfare, and safety of waiver participants.

These objectives will be met using the following procedures:

- Review of recipient records to ensure quality and appropriateness of care. Identify and compare services on the plan of care with services waiver participants actually receive to determine billing accuracy
- Review of recipient records to ensure they were given a choice of service providers
- Assess health and safety, and gather input and feedback regarding services provided
- Review personnel records to ensure that personnel meet minimum and continuing educational requirements.

REVIEW OF DIRECT SERVICE PROVIDERS (DSP)

AMA Waiver QA Program will conduct independent reviews of the DSP at the request of the OA and/or in response to complaints lodged against the DSP and as deemed necessary. The review will be done to evaluate the quality of services furnished, to ensure adequate delivery of services and to ensure the health and safety of the recipients.

The scope of the review will involve review of the DSP client records to ensure that services were provided as authorized and in accordance with the requirement of the waiver document. Review of employee personnel records to ensure consistency with minimum and continued educational requirements. Review of DSP administrative policies and procedures to ensure that the providers are in compliance with the requirements of the waiver document.

Review finding will be submitted to the OA, the waiver service provider, and AMA LTC Program Manager. A copy will be maintained by AMA LTC Waiver Quality Assurance Program. Upon request, findings will be submitted to the Secretary of HHS, the Inspector General, and CMS (See 1902 (a) (11) (c) of the Social Security Act).

OBJECTIVES:

- To assure consistency with federal and state rules regulations, and guidelines
- To assure that services are provided by qualified personnel
- To assure services are rendered in accordance with the POC and according to the waiver document
- To assure that services are authorized
- To assure the health, welfare, and safety of waiver participants.

These objectives will be met using the following procedures:

- Review participant records to ensure services are initiated promptly; rendered as authorized; skilled services ordered by a physician; and services are billed correctly
- Review Service Authorization Form to ensure service provided was authorized
- Review personnel records to ensure services are provided by qualified personnel who meet the minimum and continuing educational requirements, the licensure requirements, and are free of communicable diseases

- Review administrative policies and procedures to assure that the DSP operates in accordance with the scope of services as outlined in the waiver document.

CLIENT SATISFACTION SURVEY

The LTC Waiver Quality Assurance Program will conduct a Satisfaction Survey/REOMB (recipient explanation of Medicaid benefits) on a quarterly basis. The survey will be sent to a random sample of selected recipients/ representative. The purpose or the survey is to evaluate recipient satisfaction with waiver services. Survey results will be evaluated and reported to the LTC Program Management and the OA. The OA will be contacted regarding all adverse responses for follow through and appropriate action until resolution.

COMPLAINTS AND GRIEVANCES

OBJECTIVES:

- To assure that complaint/grievance procedures are in place and are in compliance with federal and state regulations
- To assure complaints/grievances are tracked through to resolution
- To assure adverse finding are reported to the appropriate authority for final determination
- To assure health and safety of participants
- To assure participants the right to appeal adverse decisions through the informal process and/or the fair hearing process.

These objectives will be met using the following procedures:

- Review the OA Complaint/Grievance Log to ensure appropriate resolution of legitimate complaints/grievances and for tracking purposes.
- Investigate all complaints/grievances that are received by the AMA, regarding service provisions, through resolution. A plan of correction will be requested from the OA or the provider for all substantial complaints. The plan of correction will be evaluated by the AMA and additional information requested if needed. Findings and actions will be communicated to all appropriate parties
- Analyze complaints/grievances to detect trends, patterns and to ensure the health and safety of the waiver participants
- Report adverse findings to LTC Program Manager for appropriate action and final determination
- Allow participants to appeal grievances, not resolved, by allowing them due process. Participants have the right to appeal decisions and/or request a fair hearing by the AMA.

RESPONSE TO CRITICAL EVENTS OR INCIDENTS

All Medicaid approved providers who provide home and community-based services in Medicaid recipient's home shall report incidents of abuse, neglect, and exploitation immediately to the Department of Human Resources, or law enforcement as required by the Alabama Adult Protective Services Act of 1976.

Other incidents such as falls must be reported within 24 hours to the Provider Agency, the AMA, the Alabama Department of Public Health and the Alabama Department of Senior Services in a timely manner based upon the circumstances surrounding the incident.

Each OA will investigate the critical events reported, and make a decision re: what actions are to be taken. The OA is responsible for determining the need for follow-up. Completion of follow-up is not to exceed 30 days based on the nature of the incident.

For further instructions, refer to Appendix G: Participant Safeguards of the Elderly and Disabled Waiver.

THE REVIEW PROCESS

Waiver QA Review Procedure for E/D and SAIL Waiver:

A. The LTC Waiver QA Program will conduct a review of each operating agency annually. The LTC Waiver QA Program will notify the OA in writing prior to the review, of the review date, review period and the element/information that will be evaluated during the review. Most of the review will be conducted at a central location, however, a desk review of case management records may be done at the Medicaid office and case management personnel records and home visit may be done at the source location.

B. The review process may include:

1. Review client records for documentation of
   a. Admission criteria
   b. Plan of Care
   c. CM documentation
      1. Freedom of choice
      2. Education regarding client rights
      3. Client satisfaction
   d. DSP documentation
   e. Billing
2. Review OA records for documentation of

a. The OA's onsite reviews of DSP
b. The OA's review of CM records
c. The OA's documentation of provider experience (new DSP)
d. The OA's policies, procedures and organizational structure
e. The OA's contracts with DSP's
f. The OA's qualification of employees conducting LOC determinations, and employees conducting QA activities (this may entail review of personnel file)
g. The OA's records of any complaint and grievances received.

3. Review Case management records for documentation of
   a. Basis education and initial and yearly training requirements
4. Visit client homes to determine
   a. Client satisfaction
   b. Effectiveness of service provision
   c. Appropriateness of services
   d. Adequacy of equipment and supplies
   e. General condition of home
   f. Safety of home and equipment.

- Provide the OA with a written report of review findings. The OA will have 15 days from receipt of the written report from AMA to submit written answers to any deficiencies outlined in the report.

C. The review coordinators will request case management records to conduct desk reviews. DSP records for each client in the sample will also be requested for desk review .

D. The QA Program will conduct independent reviews of DSP at the request of the OA and in response to complaints received at Medicaid and as deemed necessary.

E. The QA Program will on a quarterly basis send out satisfaction surveys to a representative sample of clients from each waiver. The results of the surveys will be tabulated and distributed to the LTC Program Manager and the OA.

WAIVER QA PROGRAM REVIEW PROCEDURES FOR ONSITE REVIEW (MRDD WAIVER) WHEN DEEMED NECESSARY

A. Prepare for the Review
   1. Complete schedule for onsite review for each waiver site provider
   2. Send letter to provider in advance requesting completion of facility report for each site
   3. Identify waiver participants at each waiver site through DSS query or 310 Board
   4. Make schedule and call provider to confirm review date
   5. Randomly select from list of participants, records for review

6. Send letter to provider identifying date and time of review, time period of review and participant records to be reviewed
7. Request recipient data sheet from AMA Fiscal Liaison Office for participant records chosen for review.

B. Conducting Review
1. Meet with appropriate contact persons (director, supervisor and or case manager) to explain review process
3. Request the following information:
   a. Recipient records
   b. Personnel records
   c. Day habilitation and group home names and location (if applicable)
   d. Direct service provider names and clients they service (if applicable)
   e. Complaint and Grievance Log
   f. Incident Reports.
4. Review recipient records for the following information:
   a. Level of care
   b. Training goals
   c. Plan of Care
   d. Quarterly Narrative
   e. Freedom of Choice
   f. Documentation of Medical Care.
5. Review personnel records for the following information:
   a. Documentation of basic education
   b. Verification of professional license if applicable
   c. Job description
   d. Documentation of training prior to service delivery
   e.. Documentation that supervisor observed working providing care every six months
   f. Evidence of being free of TB or communicable disease.
6. Conduct an onsite inspection of day habilitation sites for the following information:
   a. Facility safety
   b. Food safety
   c. Medication administration
   d. Daily activities and training
   e. Interaction between staff and clients.
7. Conduct an onsite inspection of SCLH/Group homes for the following information:
   a. Facility safety
   b. Food safety
   c. Medication administration
   d. Daily activities and training
   e. Interaction between staff and clients.
8. Notification of review findings:
   a. Conduct an exit conference to summarize the review findings
   b. Send written documentation of review findings to waiver site provider
   c. Request a plan of correction for all discrepancies identified during

the review

d. Copy review findings to the OA and LTC Program Manager.

Appendix A

Long Term Division Care Contact Information-

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Montgomery, AL 36103-5624

Marilyn Chappelle, Director
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334-242-5009

Ginger Wettingfeld, Associate Director
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