

**SAIL WAIVER**  
**Policy & Procedure**  
**Manual**

## MISSION STATEMENT

The *Mission* of the Alabama Department of Rehabilitation Services is *to enable Alabama's children and adults with disabilities to achieve their maximum potential*. This *Mission* is reflective of the broad nature of the agency which serves children with disabilities, adults who have a physical or mental impairment which constitutes or results in a substantial impediment to employment, and individuals, who because of the severity of their disability(ies), may not at the present time have vocational potential.

The *Mission* of the SAIL Medicaid Waiver is *to enhance the quality of life by providing service(s) to individuals with severe disabilities*. This will allow the individual to achieve and maintain their maximum independence in their home environment.

## INTENT

The *intent* of the SAIL Waiver program is to provide Medicaid Waiver services to eligible individuals in their home. The expense of these services to Medicaid will not exceed the cost of institutionalization and the individual's health, safety and well being will be maintained. When all services are maximized and the individual's health and safety cannot be continued to be assured, the case must be closed. Documentation to support coordination of all resources prior to termination is required.

## **HISTORY AND LEGAL AUTHORITY**

The ~~SAIL-Homebound~~ Waiver program, hereinafter referred to as the SAIL Waiver, was created by written agreement between the State Department of Education, Division of Rehabilitation and Crippled Service and the Alabama Medicaid Agency, effective April 1, 1992. The initial approval was for three years. At the end of the three year period (HCFA now CMS) performed a compliance review of the program. A joint effort between the Alabama Medicaid Agency and the Alabama Department of Rehabilitation Services resulted in a renewal application being submitted with approval for another five years. The approval was formalized by a written agreement between the Alabama Department of Rehabilitation Services (ADRS) and the Alabama Medicaid Agency (AMA), effective April 1, 1995 through March 31, 2000. The program continued to show the health and safety of individuals were being met and the SAIL Waiver was cost effective when compared to institutionalization. When the second compliance review was conducted, it was approved for the period April 1, 2000 through March 31, 2005. Other approvals were received and dated April 1, 2005 through March 31, 2010 and the most current approved for April 1, 2010 through March 31, 2015.

## **ADMINISTRATION**

The AMA deems the ADRS as the operating State Agency for the SAIL Waiver program and authorizes it to provide all services either directly or by contractual agreements with other service providers. The SAIL Waiver program is assigned the identification number: 800000001. or National Provider Identification Number of 1053489534.

The SAIL Waiver program *administers* services to Alabama residents who meet the following criteria:

- (1) Severe disability; i.e., quadriplegia, traumatic brain injury, amyotrophic lateral sclerosis, multiple sclerosis, muscular dystrophy, spinal muscular atrophy, severe cerebral palsy, stroke and other substantial neurological impairments, severely debilitating diseases or rare genetic diseases, e.g. Lesch-Nehan Syndrome. The disability is not associated with the process of aging.
- (2) 18 years of age or older with onset of disability prior to age 60.
- (3) Meets nursing facility level of care criteria.
- (4) Meets Medicaid financial eligibility.

SAIL Waiver services must be provided in accordance with a properly completed *individualized* plan of care. Services may include any or all of the following:

- (1) Case Management
- (2) Personal Care
- (3) Evaluation for Assistive Technology
- (4) Environmental Accessibility Adaptations
- (5) Medical Supplies/Minor Assistive Technology
- (6) Personal Emergency Response (installation)
- (7) Personal Emergency Response (monthly)
- (8) Assistive Technology
- (9) Assistive Technology Repairs
- (10) Personal Assistant Services (for Waiver individuals who are employed at least 40 hours per month)

The SAIL Waiver program has the right to limit the number of Medicaid Waiver participants they are able to serve. Service providers may not discriminate in the selection of the participants they serve.

## ASSURANCES

The SAIL program of the Department of Rehabilitation Services is the Operating Agency for the Alabama Medicaid Waiver Program. Medicaid determines eligibility for services to be provided without regard to sex, race, creed, age, color, national origin, or type of disability.

The case manager must document in the case record a rationale for any decision to provide, alter, or deny services.

It is the policy of the SAIL Waiver program to respect each individual's dignity when providing Waiver services. Each employee of the SAIL Waiver program will comply with the policies and procedures of the Alabama Department of Rehabilitation Services and the Alabama Medicaid Agency rules and regulations.

## 1. CONFIDENTIALITY

---

- 1.1 All applicant/participant information acquired shall remain the property of the SAIL Waiver program and the ADRS. This information shall only be used and released for purposes directly related to the administration of SAIL Waiver Program. Use and release of personal information shall conform to applicable State and Federal laws and regulations.
- 1.2 All applicants, participants, or participant's representatives are to be informed of the *confidentiality* of records. Release of such information must be by written consent of the participant or authorized representative to include:
- (a) the nature of the information to be released;
  - (b) designation of the parties to whom the information may be released;
  - (c) the specific purpose for which the released information may be used;
  - (d) designation of the agency or person authorized to disclose the information;
  - (e) date of initiation and termination of consent.
- 1.3 To the extent that another agency or organization demonstrates that information is necessary, and with written consent of the SAIL Waiver participant disability or their representative, the SAIL Waiver program may release information to the requesting agency or organization.
- 1.4 When requested in writing by the SAIL Waiver applicant/participant or, as appropriate, their representative, the SAIL Waiver program must make all information in the case record accessible and/or release the information to the SAIL

Waiver participant or to the individual or release it to their representative in a timely manner, except:

- (a) When the SAIL Homebound Waiver program believes medical, psychological or other information may be harmful to the individual, the information may not be released to the individual, but must be provided to their representative, treating physician, or licensed or certified psychologist, or requesting agent.
- (b) Information obtained from other organizations or agencies may be released only under the conditions established by the outside agency, organization, or provider.

1.5 All responses to subpoena(s) for information must be processed in accordance with ADRS policy.

1.6 An employee shall not testify in court or in an administrative hearing; or release records without the consent of the individual with a disability unless served with appropriate subpoena and ordered to do so by a judge or hearing officer.

## 2. APPLICATION PROCESS

### 2.1 Intake

Applicants may apply at any SAIL Waiver office located closest to the county in which the applicant resides. The SAIL Waiver offices may also receive referrals from family members, interested neighbors or friends, physicians, hospitals, nursing homes, or staff of a public or private agency. Agencies that may make referrals include but is not limited to the Department of Human Resources, Department of Public Health, Department of Senior Services, Department of Mental Health/Mental Retardation and private home health agencies. Out-of-state applicants must intend to locate within the geographic area. The SAIL Waiver employee cannot travel outside the State of Alabama to interview a prospective participant, as the waiver rules indicate, a survey/assessment of the home, the case manager must have access to the dwelling.

**NOTE:** In areas where referral lists have been established, the Case Manager should explore the possibility of referrals to other waiver or community programs with the individual. A referral to the Independent Living Specialist should be made so that services are provided until a vacancy occurs.

**NOTE:** If the referral cannot be reached due to a faulty telephone number, a letter should be sent to the person stating the reason for the contact and that he/she should contact the local office for screening purposes.

### 2.2 Screening and Evaluation

The case manager must complete the SAIL Waiver and Home and Community Based Service (HCBS) forms on each applicant.

For those not already Medicaid eligible, the case manager must also submit the MED-204 Application for Medicaid Benefits, so both financial and medical eligibility can be verified and established by the Alabama Medicaid Agency.

→ The applicant has 10 working days to work if they do not respond. All employees must be ready at any time.

If the participant remains in the waiting list, we should contact every 120 days to assure they can reapply at any time.

For those disabled as a result of employment, accident (automobile or other), and who have litigation pending, the case manager must complete Form XIX-TPD-1-76 and forward it to the SAIL State Office.

### 2.3 Assessment

The following HCBS-1 and SAIL Waiver worksheet forms must be completed accurately and signed during an initial home visit with the applicant:

- o HCBS-1 pages 1-4
- o Problem Solving Guide (must be in the file)
- o Application Worksheet
- o XIXTPD, 1-76 (if applicable)
- o MED 204 (if applicable)
- o Participant's Choice of Provider
- o Release of Confidential Information/HIPPA Form
- o Voter Registration Form

The SAIL case manager must ~~to~~ involve the applicant/caregiver to the greatest extent possible in the assessment process.

Every effort must be made to include the applicant in the interview and planning process. When an applicant is physically or cognitively unable to participate in an interview, a relative, guardian or primary caregiver can be interviewed for completion of the assessment. All forms remain as part of the case record.

During the initial intake, the SAIL Case Manager must explain all available services to the applicant and the family. After the explanation is complete, then waiver services are individualized to best meet the needs of the applicant. If another waiver program would more appropriately meet the needs of the applicant, a referral should be made if the applicant agrees.

*Person Centered  
Planning*

*Memo  
to page 8*

The Case Manager must explain the intent of the Applicant/Participant Choice of Providers form and ask the participant/responsible party to initial and date the choice on the form. The Case Manager will place the initialed and dated client Choice of Provider(s) form in the case record and leave a copy of the form in the home. The Choice of the Provider must be documented in the narrative.

~~During the initial visit, the case manager should discuss with the participant "Due Process" which is located on back of the Problem Solving Guide and the HIPPA form that explains the departmental rule governing release of information. The participant must sign and date these forms.~~

#### 2.4 HCBS-1 Application Forms

##### A. Assessment (HCBS-1 Pages 1 & 2):

All information must be completed in its entirety in compliance with Alabama Medicaid guidelines. Those application worksheets with incomplete information may not allow the SMILE case management system to transfer the HCBS-1 for processing. The section on the HCBS-1 page 2 labeled "Other Agencies providing services in home within the last three months" should be completed not only on initial applications, but on redeterminations as well. This includes Home Health agencies and others. Physicians, ADRS, SAIL-IL, as well as those listed on page 2 will be listed on the Plan of Care under the section labeled "NON-WAIVER SERVICES".

##### B. Admission and Evaluation (HCBS -1, Page 3)

The Case Manager is responsible for obtaining the most reliable and accurate information available at no cost to SAIL. The participant's current diagnosis and

medications are included on this page. This page must be signed by the applicant at the time of pre-admission screening to ensure that the applicant, whenever possible, is involved in planning their long term care needs. Also, the applicant/participant provides consent to ADRS to share information with vendors providing services. The applicant/participant signs showing they have been given a choice between community and nursing facility care.

**NOTE:** The choice of provider/location of service will remain in effect until such time as the participant choice changes. If the participant lacks the physical or cognitive ability required for making a written choice regarding provider of service, an available, responsible person may sign the form.

**BOTH APPLICANT AND PHYSICIAN'S SIGNATURE MUST BE ORIGINALS on the HCBS-1 page 3.**

~~The case manager must print a copy of the HCBS-1 forms in SMILE.~~ A copy of the application will be made electronically then submitted to the SAIL nurse for Nurse Determination. The original HCBS-1 page 3, with signatures remains in the participant's file for auditing purposes. The same procedure applies for redeterminations.

The primary disability and secondary condition(s) must include the complete ICD-9 code, which is computer generated from the disability data page. The disability must be written beside the code.

2. For new applications, a minimum of two (2) admission criteria is required. For redetermination of eligibility, only one (1) admission criterion is required.

*Using the Admission and Evaluation data page.*

3. If *Item A* under required services is marked indicating the administration of a potent and dangerous injectable medication, intravenous medication and solutions on a daily basis, or administration of routine oral medications, eye drops, or ointments is required, these medications must be listed in the medications section. Please note that only 12 medications can be listed in the box in the SMILE system. Additional medications are listed under Section G in the narrative.
4. If *Items B-J* are marked, then an explanation must be provided in the comment section and narrative.
  - a. *Item G*, unstable medical condition is an episode of an acute illness or exacerbation of a chronic illness that has required active treatment in the preceding 30-60 day period. If "observation of unstable conditions" is used to qualify an applicant for services, documentation of exactly what the condition(s) are and what is necessary (active treatment of the condition) to control them is required. Active treatment is defined as: i.e., doctor's orders, home health nurse orders, change in medication or new medication as part of the active treatment of the condition 30 to 60 days prior to the date of submitting the application for admission. This documentation is placed in the comment box or placed on the Plan of Care under the Non Waiver objectives, with all boxes completed with frequency and dates.

*Example for comment box:* Client gives a history of visiting MD on a

monthly basis. She reports that during her March visit that the physician increased her Blood pressure medicine to two times a day, or changed her potassium to once a day, or gave her a new prescription for arthritis that she takes twice a day. Example for Plan of Care page, Provider=physician, frequency=1xper month, during March visit physician increased B/P med to 2xday, decreased insulin to 20 units. All cases where the doctor marks Criteria G must have six (6) months of the individuals medical notes forwarded from the doctor. In cases where the individual's doctor has ordered the Home Health Nurse to provide a skill, the case manager must obtain the visit notes for the previous six (6) months. **IF CASE IS DENIED**, then go back and gather more support documentation and resubmit. Case Manager will have to encourage the participant to visit with their physician for more documentation upon redetermination and especially for new applicants who may not satisfy the definition of unstable medical condition when applying for services because the Medicaid guidelines related to definition of chronic stable state: "not during a period of any acute illness or an exacerbation of their underlying disease" A person is said to have a chronic condition or a stable condition when it has lasted for more than 6 months and there have been no significant changes or active treatment in the preceding 30-60 day period.

- b. The primary diagnosis, which is being treated, should be listed first. All other medical conditions which contribute to the applicant's functional limitations should also be listed.

**Note:** Medicaid does not pay for routine visits to the physician and therefore, will not pay for the completion of the HCBS-1 form page 3.

**C. Prior Control Number:**

Prior to submitting a new application for a waiver approval, a prior control number will be generated in the SMILE system. The first three numbers identify the provider of waiver services "8" = SAIL Waiver, and the waiver participant's country code, i.e. "43" = Lee County. The next six numbers are a sequential run of numbers for approved SAIL Waiver participants, 500-001, 500-002, etc. This specific prior control number will continue to be used to identify each participant throughout the receipt of services, even if there is a break in service. The prior control number remains assigned to the designated participant and cannot be reused if that participant enters a nursing home or is terminated from the waiver for any reason including death until the beginning of the new waiver year. Waiver slots assigned during the waiver year cannot be reused for any reason. At the beginning of the new waiver year, slots left vacant during the previous year can be used. It is the case manager's primary responsibility for the completion of the HCBS-1 page 3. The form should not be completed by the applicant/participant. After completion, the form is then sent to the person's physician for signatures.

**D. Plan of Care (HCBS-1, pg. 4)**

1. The case manager and recipient will develop the *Plan of Care* (HCBS-1 from, pg. 4). The *Plan of Care* must include objectives, services, providing Agency/resources, and the frequency of service(s). All services, both waiver and non-waiver, which are needed to maintain the individual within the home and community should be listed on the *Plan of Care*.

2. Services listed on the *Plan of Care* must be based on the applicant's diagnosis as stated on the HCBS-1 form, pg. 3. All services provided, including those from other resources, including informal family support, must be included.
3. Exact Waiver service category titles must be used on the *Plan of Care*. Specific entries will accurately identify the provider(s) of each waiver and Non-waiver services which may include, home health, routine visits to the physician, ADRS services, SAIL-IL, and any other entities providing services.

#### 2.5 Application Narrative

An application narrative must be completed and the following addressed:

- Describe personal background, disability, home environment.
- Describe needed waiver services, justification of services and provider of services, if selected.
- Describe non-waiver services, justification of services and provider of service(s), if selected.
- Describe any similar benefits.
- Discuss applicant/participant rights and responsibilities.
- Discuss emergency protocol.
- Discuss client -at-risk.
- Describe Participant Choice.

Additional Medications in excess of 12 should be typed in **Section G-Other Information** on the SMILE Application Narrative page. Also included here is any information pertaining to changes made by the case manager after consultation with the physician's office.

#### 2.6. Special Income Level Recipients

A special income level may be used for the SAIL Waiver. A participant may have income that is 300 percent of SSI payment rates. Individuals with income in excess of the current SSI amount but not exceeding 300 percent of may be financially eligible. HCBS-1 forms are completed and dated. The HCBS-1 application is considered to be in pre-admission status. Assessment for financial eligibility for 300% cases will be processed by the Alabama Medicaid Agency and will be forwarded by Medicaid or the Case Manager to the District Office serving the individual's county or residence.

1. If SSI or SSDI disability is already in place then the SAIL Waiver Case Manager will:

- Submit a 204 form to the local Medicaid District Office (M'caid DO) accompanied with Medicaid Waiver Slot Confirmation Form signed by the SAIL Nurse Reviewer and the SAIL case manager. This is a financial eligibility determination form, which is reviewed and processed by the Medicaid District Office, Eligibility Division. A photocopy of the MED 204 should be retained in the client file.

**NOTE:** Only original copy of the MED 204 form will be accepted by the Alabama Medicaid Agency. Once the financial determination is made by the Medicaid District office, the information will be faxed to the SAIL State Office for entry into the SMILE system. If no disability determination has been made (the participant does not receive SSI or SSDI), the SAIL Case Manager will:

- Obtain the additional medical information, (with diagnosis and pertinent information) such as physician office notes, hospital

records, etc., necessary for the Medicaid Physician to make a medical disability determination.

- Mail the HCBS-1 Application form, the Application Narrative, and the above information to Medicaid Long Term Care, Admissions Records Division. The Medicaid nurse reviewer will then attach the forms necessary for the disability review and route this to the Medicaid Physician. The Medicaid Physician will determine medical appropriateness as well as disability determination on these individuals. The MED204 will be signed by the SAIL Nurse and forwarded to the local District Office after receiving the medical eligibility approval from Medicaid.

**NOTE:** Enter the following statement in the comment box: *Medical information submitted mailed to Medicaid LTC.*

#### 1.7 Institutional Deeming Process

The Institutional Deeming process may be used to disregard the income of a potential waiver recipient's parent or spouse. When considering the parent or spousal income, it may appear that the applicant would not qualify financially for waiver. Institutional Deeming allows for the application to be made to Medicaid and requests that the other income be disregarded.

Individuals using the Institutional Deeming process or the 300 per cent of SSI criteria to become eligible for Waiver services will have to complete the MED204 form.

**NOTE:** *Only original copy of the MED 204 form will be accepted. Xerox copies will not be accepted by the Alabama Medicaid Agency.*

#### 2.8 Pre-Admission Review

Pre-admission review is completed by a case manager for an applicant who applies for SAIL Waiver Program. If the applicant's assessment is older than twenty (20) working days at the time the applicant becomes eligible, the case manager must contact the applicant/responsible party to confirm the information obtained in the assessment is current. The contact must be made before the *Plan of Care* is finalized and documented in a case note. The assessment information must provide accurate and comprehensive information for the case manager to develop a "*Plan of Care*". The HCBS-1 forms must present a clear picture of the applicant's medical status and functional abilities, and home environment as needed to support the assessment. In addition, the following information must be addressed and documented in the client record by the case manager: level of care, location of case, Medicaid eligible, and slot availability.

#### 1.8 Payment Authorization/Participant's Status Notification Form Eligibility Page

This page appears in the SAIL Waiver SMILE System. When an applicant or participant is determined eligible for initial assessment, redetermination, or readmission, the page is updated in the computer upon receipt of approval from EDS. Once the approval is transmitted and updated in the computer

system, the SAIL State office will notify the case manager by e-mail approval has been received. It is the case manager's responsibility to print this data page for placement in the participant's record. Services listed on the Plan of Care will be initiated for the participant upon receipt of eligibility notification. For new cases, the case manager has five (5) working days from the receipt of the e-mail to make the initial home visit to initiate services.

**NOTE:** A separate folder should be kept for all financial information that should include the following placed in the order as listed: supply authorizations, authorizations requiring prior approvals, personal care orders, and personal care authorizations.

Based upon Medicaid's suggestions, a participant record folder should be divided into the following six (6) sections with current information on top:

1. Application Narrative followed by Case Management Service Review, documenting face to face visits, and Case Notes for documentation of interim events. Documentation from the DSP for PC/PAS regarding Supervisory Visits will be filed in this section.
2. Plan of Care (HCBS-1 Form, pg. 4). *Don't print*
3. Pending and Holding.
4. Admissions and Evaluation forms and any other medical information (HCBS-1 Form pg. 3).
5. Home and Community-based Services program assessment (HCBS-1 Forms, pgs. 1 & 2), eligibility information (XIX-TPD-1-76 and MED 204 Form if applicable). The XIX-TPD-1-76 is to be mailed to

*Need to re work*

**ADRS Third Party insurance through the SAIL State Office.**

- 6. Miscellaneous information, correspondences, and Special Programs and Personal Information data pages.**

### 3. ELIGIBILITY

---

If a participant is not presently eligible for Medicaid or SSI and is seeking Medicaid sponsorship in a long-term care Waiver Program, the MED 204 financial application form must be submitted to Medicaid with the HCBS-1 forms (review 204 form p12-14). The Case Manager should always inform the applicant and/or responsible party of the application process. If an applicant is not currently receiving Supplemental Security Income (SSI) and it appears he/she may qualify, the applicant should be referred to the Social Security Administration, unless a recent application has been made. Both Medical and Financial Eligibility is determined by the Alabama Medicaid Agency.

**NOTE:** *For certifying agencies, see Alabama Medicaid Policy & Procedure Manual. The three certifying agencies are: Alabama Medicaid Agency, Social Security Administration, and the Department of Human Resources.*

#### 3.1 Verifying Eligibility

The Alabama Medicaid Agency, based on information supplied by Case Manager (See Application Process) determines eligibility. The SAIL Waiver eligibility decision is returned to the Case Manager via the Eligibility Page. Upon notification of eligibility, the Case Manager must visit the participant within five (5) working days to finalize the Plan of Care and discuss the choice of Waiver service(s) provider(s).

**NOTE:** *If the participant is not physically or mentally able to complete and/or sign the Choice of Provider(s) form, the responsible party may do so for the participant. The lack of a signature on the form will not preclude the participant from receiving waiver services. The participant may receive waiver services as long as a written choice is indicated on the form.*

### 3.2 Medical Eligibility

The target groups for Homebound Waiver Services will meet the Nursing Facility Level of Care Criteria and will specifically provide services to individuals with physical disabilities not associated with the process of aging and with onset of the disability prior to age 60. Waiver Services will be provided to, but not limited to persons having these diagnoses: quadriplegia, traumatic brain injury, amyotrophic lateral sclerosis, multiple sclerosis, muscular dystrophy, spinal muscular atrophy, severe cerebral palsy, stroke and other substantial neurological impairments, severely debilitating diseases or rare genetic diseases, e.g. Lesch-Nehan Syndrome.

In addition to the financial and medical eligibility criteria, the exact number of approved waiver slots for each year will be listed in the approved waiver document.

### 3.3 SAIL Homebound Waiver Services cannot be delivered to individuals with the following circumstances:

- Residing in a domiciliary (Assisted Living Facility ALF).
- Residing in a nursing facility/swing bed.
- Receiving services through any other approved and implemented HCBS Waiver Program.
- Primary diagnosis of mental illness and/or mental retardation.
- Residing in a boarding home (Medicaid sponsored).
- Choosing nursing facility care.
- Resident of to another state.
- Health and safety is at risk in the community as determined by the Alabama Medicaid Agency and/or the Administering State Agency.
- Medicaid eligibility blocked due to transfer of assets.
- In a hospital or other acute care facility.

- In a hospital swing bed.
- The Medicaid Agency and/or Administering State Agency determine if there is reasonable expectation that Waiver Services would be more expensive than institutional care.

***Denials by the Operating Agency:***

The Operating Agency or SAIL staff can deny an application for admission to the waiver for any of the following reasons:

- No physician's certification
- Medical documentation does not support established admission criteria
- A new admission application that has less than two (2) medical criterion certified on the application
- A request for additional medical information necessary to process the application is not received within 60 days
- The Operating Agency cannot safely maintain the individual in the community
- The waiver does not cover the eligibility group

3.4 The Eligibility Page will specify a beginning date of eligibility for Waiver services. Any services rendered prior to this date will not be paid under the waiver. Waiver services are not retroactive. By the beginning of each month, eligibility status should be verified and documented on each participant prior to the end of the first week of the month by accessing the MSIQ screen.

3.5 Service Initiation

Once the case manager receives the notification of eligibility, services should be implemented and provided according to the Plan of Care. Those Waiver services may include:

- 1) Case Management
- 2) Personal Care
- 3) Evaluation of Assistive Technology
- 4) Environmental Accessibility Adaptations
- 5) Medical Supplies/Minor Assistive Technology
- 6) Personal Emergency Response System (Installation)
- 7) Personal Emergency Response System (Monthly)
- 8) Assistive Technology
- 9) Assistive Technology Repairs
- 10) Personal Assistant Services (for Waiver individuals who are employed at least 40 hr hours per month).

It is the responsibility of each SAIL Office to keep a continuously updated list of providers for each Waiver service available in the area. A copy of this list is given to each participant and/or primary caregiver at each initial visit and annual re-determination visit. The participant must always be informed of providers serving their area.

At any time, the participant and/or primary caregiver may request an additional Waiver service or a change in providers. The case manager must narrate this information exchange as well as review the choice of provider(s).

Special needs of the participant, such as weekend service or specific hours of the day or evening should be reflected on the service provider contract and documented in the case narrative. These needs will be presented to the chosen provider, giving that provider the opportunity to accept or reject the referral.

The case manager must make a face-to-face visit in the home with the participant every month and document observations and verbal exchanges.

### 3.6 Reviews:

A review of the *Plan of Care* will indicate any adjustments in services as needed. The case manager will use eligibility date to establish 30/60 day schedule.

**NOTE:** For example, if the eligibility date is January, the 60-day review is due in March. If the eligibility date is February, the 60-day review is due in April. If eligibility date is January, the 30-day review is due in February.

### 3.7 Annual Redetermination of Eligibility

To remain eligible for Waiver services, the participant must be re-evaluated each year. This process should be initiated two (2) months prior to eligibility end date. On page three the "Admissions and Evaluation page of the HCBS-1 only one (1) Admission criterion has to be met.

The case manager will coordinate completion of HCBS-1 forms, pages 1-4 and submit to the SAIL Nurse for eligibility determination. Once approved, the application will be electronically transmitted to EDS for acceptance for the participant's new waiver year. To prevent a lapse of participant services, the forms should be submitted no earlier than 45 days prior to the end of the participant's current eligibility date.

#### **Early Redetermination Process:**

Early redetermination is a process which assists the case managers in redistributing their monthly case load for redeterminations. The process is to submit a Long Term Care Request for Action Form with the current end date and the new end date. The new end date will be the last day of the month with the new redetermination date to begin on the same day of the month. A completed LTC Request for Action Form is enclosed for your reference. Also, send written consent with client's signature indicating the early

redetermination has been discussed with the client and that he/she is in agreement with early redetermination.

The Waiver Quality Assurance Program Review Nurse will enter the new end date and return the LTC Request for Action Form to you to submit the new redetermination date through the LTC Notification software.

### 3.8 Readmission

If eligibility has lapsed before a redetermination has been completed the application is considered a readmission, which establishes a new eligibility period. Two (2) Admission Criteria must be met. The Case Manager will be expected to have supporting documentation of an unstable medical condition that would indicate an episode of an acute illness and active treatment within the past 30 to 60 days (relative to checking G under Admission Criteria which reads Observation of unstable medical conditions required on a regular and continuing basis that can only be provided by or under the direction of a registered nurse.

### 3.9 Service Interruption

If a Waiver participant is temporarily hospitalized for less than one full calendar month, the case should remain open to Waiver but placed in an interrupted status. The only Waiver service to be provided is case management limited to telephone contact. Interruption should be documented in a case note.

Upon release from the hospital, the case manager should verify and document the participant's status, update the Plan of Care and reinstate services.

**NOTE:** When a participant enters the nursing home, the SAIL waiver case must be closed within 48 hours of nursing home admission. If the participant returns home, a readmission to waiver is required.

### 3.10 Re-instatement

SAIL waiver participants who are institutionalized in a nursing home during an active re-determination period and whose nursing home stay does not exceed one hundred (100) days can be reinstated to the waiver slot vacated by the recipient. The following must occur for re-instatement to occur:

- Once the participant is admitted to the nursing home, the case manager must close the waiver case within 48 hours denoting the discharge date.
- A reassessment must be completed and services resumed within ten (10) days from the nursing home discharge date. The case manager must conduct a face to face visit before services are resumed. The District Office must be notified by the 15<sup>th</sup> day of the month of the discharge date. Those who miss the 15<sup>th</sup> deadline date must wait until the next month to return home and have waiver services reinstated.

***Example: Ruth goes into a nursing home on February 2, 2010. She remains there until a discharge date is set for March 3, 2010. The case manager must notify the Medicaid District Office immediately. Waiver Services cannot begin until April 1, 2010.***

- The full HCBS-1 application must be updated, with the exception of the Admission and Evaluation Data page (Medical form)
- The HCBS-1 Plan of Care start dates must be updated for all services-including case management services

- The course of events related to the nursing home admission and the discharge should be clearly documented on the HCBS-1 Application Narrative to reflect nursing home admission date, nursing home discharge date and the date the waiver services were ended and resumed. It is understood that in some instances the family may not notify the case manager upon the participant's discharge. The case manager will resume services as soon as possible, but no later than 10 days after notification occurs.

In the event that the participant's nursing home stay exceeds the 100 days, a re-admission to waiver is required. If the participant's waiver eligibility expires during the time of the nursing home stay, but during the waiver year, a re-admission is required. If the participant's eligibility has expired and a new waiver year is underway, the person will be placed on the referral list and an application taken as a slot becomes available.

#### 4. **TERMINATION:**

---

A Waiver case may be closed for any of the following reasons after consultation with the SAIL Coordinator:

- 1) \*Conduct which adversely impacts the program's ability to ensure service provision or to ensure the participant's health, safety, and welfare. Ex.: Evidence of sustained alcohol or drug abuse.
- 2) Closed to SAIL-Homebound case. Ex.: Participant chooses SAIL-Homebound over Waiver.
- 3) Death
- 4) Financially Ineligible
- 5) Institutionalization – Nursing Home (Closure within 48 hours of admission)
- 6) Hospitalization for more than one full calendar month

**NOTE:** *A full calendar month is defined as from the first instant of the month throughout the last instant of the month. For example, if a participant enters a facility before 12 a.m. (midnight) on the 1<sup>st</sup> day of April and remains throughout the end of April, then closure must occur April 30<sup>th</sup>. However, if the participant enters a facility after 12 a.m. (midnight) on April 1<sup>st</sup> or on any other day in April, closure must occur on May 31<sup>st</sup>. If the participant remains hospitalized or institutionalized for a full calendar month, the case must be closed to Waiver effective no later than the last day of the full calendar month period and the services, which were previously suspended, must be terminated. The case must be terminated. In order to facilitate a re-admission for the participant expected to return to the Waiver, the case manager will document discussion of discharge plan with the hospital social worker or RN and primary caregiver of the participant's impending discharge.*

- 7) \*Medically ineligible – Participant no longer meets one-admission criteria (Item A-J, HCBS-1, pg. 3).

- 8) \*No longer desires services.
- 9) \*No longer eligible (i.e. participant moves out-of-state).
- 10) \*Non-compliance with Plan of Care. If a participant and/or primary caregiver refuse to cooperate and all alternatives have been exhausted, the individual may be terminated.
- 11) \*Out-of-state for 60 days. If a Waiver participant leaves the State, the case may remain open for no longer than sixty (60) calendar days from the date of the participant's departure, as long as he/she remains Medicaid eligible and there is intent to return to the State. If the participant continues to remain out-of-state after 60 days, the case must be closed to the Waiver and all services terminated.
- 12) \*Physical Abuse. This may be physical abuse to self, providers or Waiver staff.
- 13) \*Refusal to Cooperate. Repeated refusal to cooperate with providers and/or case managers.
- 14) Transferred to another Waiver (i.e. MRDD, E&D).
- 15) \*Verbal Abuse. This applies to abuse directed to providers and/or Waiver staff.

**\*NOTE:** *The participant and/or primary caregiver must be notified in writing of the case closure.*

**\*NOTE:** *When closing a case that has Medicaid due to 300%, the case manager must also notify the local District Office*

**4.1. Re-admission after hospitalization over one calendar month or closure due to institutionalization.**

If a participant is terminated and requests to be re-admitted to the Waiver, the application process will be the same as an initial assessment and requires two admission criteria.

**NOTE:** *The prior control number will remain the same if re-admission is within the same Waiver year.*

#### 4.2. Financial Ineligibility

If at any point a Waiver participant becomes financially ineligible, all services must be terminated and the case must be closed to Waiver effective the date of financial ineligibility.

A participant's Medicaid ineligibility must be verified and documented by the case manager before the participant is terminated from the Waiver.

Special efforts must be made to contact and discuss possible alternatives with the participant and/or primary caregiver if the participant requires services in the community. Referrals should be made on the participant's behalf to other community agencies.

A Waiver participant who loses financial eligibility for Medicaid *for not more than one month* due to excess resources, lump sum payment, etc., and is closed can immediately be re-entered into the Waiver program after both financial and medical eligibility have been re-established and verified. The case should be opened as a re-admission.

**NOTE:** *Case managers can bill contacts with participant as administrative case management.*

5. **SAIL WAIVER TRANSFERS**

---

5.1 County to County within the service area.

If a participant moves within the same service area (no change in case manager) but the county changes the following procedures should be followed:

- a. Update the personal information data page in SMILE to include the driving directions to the new location.
- b. If the participant changes physicians, a new HCBS-1, pg. 3 (Admission and Evaluation form) must be completed.
- c. Instruct the participant/family to notify the Medicaid District Office if address or telephone number changes.
- d. Re-assess the home and living situation to ensure that services are still appropriate.
- e. At the time of the participant's annual re-determination, ensure that the new county code is entered for the participant.

5.2. County-to-County outside of the original service area.

When a participant transfers from one county to another within the State, the original case manager should:

- a. Send the original case file and cover letter including any pertinent information about the participant to the case manager in the office of the participant's new county of residence.

The case manager in the area office of the new county of residence should:

1. Interview participant and verify continued eligibility.
2. Complete and submit new HCBS-1 forms and arrange for services. A new physician's signature is not required if the participant remains under the care of the same physician and the services remain the same.
3. Retain new HCBS-1 forms with appropriate changes to the LTC Admissions/Records, Alabama Medicaid Agency. The prior control number must be changed to indicate the new county code at the time of the participant's annual redetermination.
4. The Alabama Medicaid Agency will generate notification of transfer and send it to the transferring area office. The LTC-2 will also be sent to the area office in the new county with the new dates of service.
5. The receiving case manager will be responsible for making all changes to the Personal Information data page.

5.3. Waiver- to-Waiver Transfer

It is possible to transfer from one Home and Community-Based Services Waiver to another provided the services are appropriate and all eligibility requirements are met.

**NOTE:** *Slots left vacant by a transfer to another waiver cannot be filled again until the beginning of the new Waiver year. If a participant elects to transfer from one Waiver to another Waiver there must be very close*

*coordination between the case managers of the Waiver programs. There must be a pre-screening by the SAIL Waiver Case Manager. The SAIL Waiver Case Manager will interview the participant and complete the initial application HCBS-1 forms, document on HCBS-1, pg.2, "transfer" in the comment box, and submit to the Alabama Medicaid Agency for notification of transfer. A copy should be sent to the SAIL State Office and one maintained in the participant file. A copy of the LTC-2 received from the transferring agency should be faxed to the Alabama Medicaid Agency with notation "transfer case has been submitted". This coordination will help ensure a smooth transition and avoid unnecessary problems or delays in the transfer process.*

The transferring case manager should:

- 1) Send a cover letter containing pertinent information is mailed to the receiving Case Manager. A copy of or Eligibility Data Page and cover letter must be mailed to the SAIL State Office and a copy maintained in the participant file. Alabama Medicaid Agency /Long Term Care personnel should be notified that the participant's case is being transferred to ensure a smooth transition.  
Transfer information must be keyed in the comment box on the HCBS-1, pg.2.

The receiving SAIL Waiver case manager should:

- 1) Verify continued eligibility after the effective transfer date.

- 2) Ensure that all receiving Waiver eligibility requirements are met prior to the authorization of services.
- 3) According to the new Plan of Care, arrange and begin providing services.

**NOTE:** *For Waiver-to-Waiver transfers, always terminate services on original Waiver on the last day of month and start service delivery on new Waiver on the first day of the following month.*

5.4 Replacement of Terminated Participant (substitutions) when all Waiver slots are filled.

No waiver slots can be refilled during the waiver year. At the beginning of the new waiver year those slots will become available.

**NOTE:** *A Waiver year is April 1 to March 31.*

Waiver slots vacated by Waiver-to-Waiver transfers cannot be refilled until the beginning of the next Waiver year.

## 6. QUALITY ASSURANCE

---

The SAIL-Homebound Quality Assurance program, through review of case documentation, is designed to assure:

- 1) Statewide program consistency,
- 2) Timeliness in provision of services,
- 3) Quality of services provided and the scope of services available to the participant.

In addition to Quality Assurance reviews performed by the Alabama Medicaid Agency, the components of the SAIL-Homebound Quality Assurance program are:

- Annual review by SAIL Coordinator
- Annual review by Program Specialist
- Peer review of random selected cases annually
- SMILE Review, random selected cases annually

QA Documentation:

**Eligibility:** MSIQ Screen should be checked monthly and dated included in a case note (see case narrative form in the sections).

**Services Received:** Included all services outlined on the plan of care within the period of time planned.

**Justification of need:** state a reason for the participant need of SAIL service(s) as outlined on the plan of care. Example: Mr. Box has a diagnosis of quadriplegia leaving him in need of personal care assistance with activities of daily living and specialized medical supplies for the protection of skin integrity.

**Benefit of services:** Describe how waiver service(s) helped the participant to remain in the home and out of the nursing home; tell how medical supplies, assistive technology, environmental accessibility adaptations, PER, or Personal Care maintains or improves the status of the participant's physical condition.

**Satisfaction:** include in the narrative that the participant/family are happy with the services they receive, as well as the vendors and providers of choices deliver services.

**Health and Safety:** describe whether or not safety needs are being met (family, other health care agencies, friends) this should be included on the plan of case under non Waiver services. If living alone, document health and safety supports in place during the time alone, especially when the personal care worker leaves the home.

**Family support:** State just how the family is involved in the care of the participant and justify if the personal care worker is a family member.

**Missed visit attempted:** Include in the documentation attempted visit with a follow-up visit to the home. Document the missed visit and the follow-up visit.

**Documenting Choice:** Include in the narrative selection of vendor by choice, complete a vendor choice form, and the provider contract for personal care.

**Complaint/Grievance Log:** Keep a file in the local office for the record of Complaint/Grievance and the action taken should be included in the documentation. Each office is to send the complaint log to the state office by the 5<sup>th</sup> day of the month following the end of the fiscal quarter. (December 31, March 31, June 30 and September 30). From there a report will be generated and sent to the Alabama Medicaid Agency Long Term Care Quality Assurance division. Case managers are to investigate all complaints logged in the local office immediately. A report of that investigation should be noted in a case note. The complaint and the steps taken to resolve it should be documented in the log and in a case note.

## CHAPTER 1

The SAIL Homebound Waiver Policy and Procedure Manual are designed for consistency and clarity and to ensure all district offices are adhering to the same guidelines.

Questions concerning billing procedures or specific status of claims should be directed to ADRS third party billing or Computer Services.

The SAIL Homebound Waiver Program provides specialized services in addition to the regular State Plan Medicaid Services. Such services are based on individual need. Those with the greatest need should be given priority on a first come, first serve basis. All efforts should be exhausted to screen referrals and network with community resources rather than keeping individuals on a long-term waiting list. All appropriate referrals should be made to other waivers. There should be no waiting list as long as the waiver has slots available. Other Waivers are available based on qualifications set by Medicaid.

### A. General Information:

1. The Appointing Authority for ADRS is the Commissioner.
2. The SAIL Coordinator directs the SAIL Medicaid Waiver Program.
3. The Alabama Medicaid Agency is a joint Federal-State program, which provides necessary medical services to eligible recipients. SAIL Homebound Waiver is granted permission to provide "*specialized*" medically necessary services described in the Service section of this document.

### B. Participant Identification

All eligible participants are given a Medicaid ID number consisting of 13 digits.

- C. Upon approval, participants are issued a Medicaid card; others approved will already have been included in the Medicaid State Plan and will already have a Medicaid card.

### D. Fiscal Agent

1. The present fiscal agent is HP Enterprise Service, P. O. Box 244035, Montgomery, 36124-04025. The toll free number for provider inquiries is 1-800-688-7989. EDS prepares and distributes provider billing manuals upon request.
2. Unsolved problems or provider dissatisfaction with the response of the fiscal agent should be directed to Alabama Medicaid Agency, P. O. Box 5624, Montgomery, AL 36103-5624, Attention: LTC/Consumer Service/Claims Administration.

## **CHAPTER II                      SERVICE PROVIDER CONTRACT**

---

To participate in the SAIL Waiver Program as a Service Provider, certain provider qualifications, licensure and certification requirements must be met.

### **A. Condition(s) for Service Provider Participation:**

- (1) A Memorandum of Agreement stipulates guidelines for the provider participation.
- (2) The participant is guaranteed relief of any liability to pay any additional cost for service.
- (3) Providers have a right to limit the number of Medicaid participants they are willing to serve; however, providers may not discriminate in selecting the Medicaid Waiver participants they will serve.
- (4) On-site quality assurance reviews of service providers will be conducted at least bi-annually to determine compliance with regulations.

### **B. Record Requirement:**

- (1) Service Providers must maintain records to contain pertinent information on the personal care worker.
- (2) Quality Assurance reviews are performed on PCW records for compliance.

## **CHAPTER III – PLAN OF CARE DEVELOPMENT**

---

Development of the Plan of Care involves objectively consulting, discussing, advising, and listening. The case manager is in a position to confer with the participant and/or responsible party or knowledgeable others concerning needs and to provide information that will assist them in making sound long term care decisions. This process includes educating the participant and responsible party or knowledgeable others with the long-term care options available to them and ensuring the participant's right to be involved in planning his/her care. The various service options and their expected outcomes should be clearly explored with the participant and/or responsible party or knowledgeable others.

The case manager must review the strengths and problems identified through the assessment process as well as viable solutions. It must include resources currently utilized by the participant, waiver and non-waiver, as well as those additional services, which may be available to meet the participant's needs.

All payment sources where appropriate, should be considered prior to using Medicaid services (including waiver services) on the Plan of Care.

Each Plan of Care should be individualized for a particular participant and completed so that a service professional unfamiliar with the participant can have, by reading the Plan of Care, a clear picture of what is being done for the participant. The Plan of Care must include the following for each service provided:

- Objective
- Service
- Provider Agency
- Frequency
- Starting Date
- Ending Date

**Objective:** To evaluate the effectiveness of a Plan of Care, the expected outcome or objective must be identified. An objective may be rehabilitative, maintenance or participant/caregiver oriented, as appropriate. The objective is developed as a joint effort between the participant, responsible party and case manager.

**Service(s):** All services must be listed on the Plan of Care as written in the Medicaid Waiver document.

- Waiver services should be listed in the first section of the Plan of Care where indicated.
- All non-waiver services should appear on the Plan of Care where indicated.
- Services will be delivered according to the Plan of Care.

- Payment will not be made for services not listed on the Plan of Care
- Services must be identified on the Plan of Care by correct service name in the approved waiver document.

**Examples:**

<u>Correctly Listed</u>	<u>Incorrect Listed</u>
Personal Care Assistive Technology Environmental Accessibility Adaptations	Attendant Care Wheelchair Home modifications

**Providers:**

Agencies that employ personal care workers.

- Identify the agency, etc. that is providing the service.  
Example: Care Plus, Inc.

**Frequency:** This must be spelled out. A range of service is not acceptable.

- For Case Management you can use for example:  
1 F to F mo visit;
- Medical Supplies you can use for example:  
Max Allocation/yr.
- For Personal Care you can use for example:  
6/hr/3das/wk; if there is a difference in time and days week, then for example: use a second line to indicate that you are providing personal care again for additional time as 5hr/d/2xwk;
- PERS is daily;
- Assistive Technology and Environmental Accessibility Adaptations and PERS Installation is written as "One Time"

*Note: Service frequency should be specific on initial and annual Plan of Care. Service frequency will only accept 20 characters including spaces.*

**NOTE:**

**IF THE CORRECT NAME OF THE SERVICE IS NOT ON THE PLAN OF CARE, IT WILL NOT BE PAID.**

**IF THE SERVICE IS NOT AVAILABLE, DO NOT PUT IT ON THE PLAN OF CARE. SERVICES ARE NOT INTERCHANGEABLE.**

**IF PERSONAL CARE HOURS VARY, THEN TWO SEPARATE LINES MUST BE USED.**

**IF THE PLAN OF CARE IS NOT COMPLETED PROPERLY, IT WILL BE RETURNED TO THE CASE MANAGER.**

***Date Service Begins and Ends:***

1. The date service begins should be on the Plan of Care.
2. On initial applications, service date should remain blank. When the Eligibility notification is sent and the page printed for the file, the case manager should enter the beginning date of each service.
3. The Eligibility Page is an authorization payment computer-generated form originating at the Alabama Medicaid Agency. The form is used to notify case managers of the approval dates. Upon notification of eligibility, the case manager should check all information for accuracy.
4. Medicaid will not pay for waiver services claimed during a period of ineligibility.
5. If the eligibility has lapsed before a redetermination has been completed, it is considered a re-admission, which would establish a new liability period.
6. A participant may sign the Admission and Evaluation Form with an "X" followed by a statement --Mark of recipient's name-- and the mark must be witnessed. If a participant is physically impaired to the extent 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 as to why participant did not sign and the person who signed must be identified in the case narrative.

***Changes in the Plan of Care:***

1. If there is any change in Personal Care, a new provider contract is written and mailed to the provider for signature and reflected in the case note or narrative and a copy placed in case file.
2. The case narrative should also reflect the need for the revision and the authorization by the case manager. Anytime services are removed or reduced a ten (10) day notice should also be sent to the participant. It should be documented in the case narrative and a copy in the participant's file.
3. When there is a change in provider or frequency, put an ending date on that service and the new service must be re-entered on the Plan of Care with the new service date. The narrative should reflect the reason for change.
4. The start dates for Assistive Technology, Environmental Accessibility Adaptations and Personal Emergency Response System is the date the PA Process begins (which is the date of the price quote received from the Vendor).
5. Ending dates for Case Management, Medical Supplies, Personal Care, PERS (monthly), is the last date that the participant received services. Ending dates for Assistive Technology and Environmental Accessibility Adaptations is the date the participant signs the Participant Satisfaction form indicating satisfaction.

## **CHAPTER IV - CASE MANAGEMENT**

### ***PHILOSOPHY OF LONG TERM CARE***

The philosophy of the Alabama Long Term Care Division and the SAIL Waiver Program is to optimize the client's life choices and rights, to minimize threats to the clients' safety and health, and to provide the mechanism for managing home and community based alternatives to institutional care.

The Long Term Division operates on the following principles supporting the case management philosophy.

- To provide a mechanism for utilizing cost effective alternatives to institutional care and to provide services for those clients eligible within the constraints of affordability by maximizing the utilization of available resources.
- To ensure services are appropriate to the needs of individual clients, are of acceptable quality, and to avoid duplication of other formal services.
- To recognize and strive to honor the client's decision regarding location of care and services received. However, a decision to receive services, including case management and the case manager responsible for the service, cannot be based on race, color, religion, or national origin.
- To acknowledge and respect the client's right to be treated with consideration and dignity.
- To augment and not replace family members and other informal support systems currently involved with the client's care.
- To make service decisions based on comprehensive, on going assessments, which include input from the client and the client's primary caregiver.
- To provide a well defined, viable, and accessible point of entry for long-term care services.

## **SAIL WAIVER PARTICIPANTS RIGHTS AND RESPONSIBILITIES:**

During the initial visit, the Case Manager should discuss the Participant's Rights & Responsibilities with the participant or responsible party. The Case Manager should document this discussion in the narrative. A copy of the HCBS-1 Form will be found in the Appendix.

- Participant will maintain contact with Case Manager.
- Participant will advise Case Manager immediately if admitted to hospital or nursing home.
- Participant will advise SAIL Case Manager immediately if going out of state more than one week.
- Participant will notify Case Manager immediately, if any changes in Medicare, Medicaid, private insurance, home address or phone number.
- Participant understands that he/she must be available for a monthly face-to-face visit in the home. Failure to do so may result in termination of service.
- Participant will only order approved medical supplies.
- Participant will inform Case Manager of Personal Care Worker leaving without giving notice.

Case Management is a waiver service that is provided to all participants who participate in the Waiver Program. Case management is a vital part of the HCBS services available to Medicaid eligible participants and ensures continued access to this system.

Some participants may choose and/or need only case management services. However, it is doubtful that being the only service needed in such situations, the value of case management is in the continued follow-up, coordination and monitoring of services other than Homebound Waiver Services. The Case Manager will also be able to periodically evaluate any changes in the participant's service needs.

Case Management includes the following six (6) activities, which are explained in the service section (Chapter VII) of this document:

- ▶ Assessment
- ▶ Level of care determination
- ▶ Choice of location
- ▶ Monitoring
- ▶ Coordination
- ▶ Re-evaluation

## Monitoring:

Upon entry into the waiver, the case manager periodically monitors the plan of care for each participant in the waiver program. Monitoring should be accomplished through monthly face to face contacts with the participant, responsible party, and /or knowledgeable other and if at all possible and with other agencies and providers included in the Plan of Care.

When an application has been approved and services have begun, it is the case manager's responsibility to reassess the needs and progress of the participant periodically. The Plan of Care must be reviewed and initialed every (60) days by the case manager.

The case manager should provide the participant, responsible party, and/or knowledgeable others with the *SAIL Rights and Responsibilities* and the *SAIL Problem Solving Guide*. The participant, responsible party, and/or knowledgeable others should be instructed to notify the case manager if services are not initiated as planned, if the participant's condition changes or if changes are needed in the plan of care when problems are identified or reported. The case manager is responsible for investigating all complaints that any participant has. The *SAIL Rights and Responsibilities* and *SAIL Problem Solving Guide* must be reviewed each year and a new form placed in the client record at the time of redetermination.

The case manager must address and document the following at monthly contacts and redeterminations:

- participant's current/health, safety and environment
- appropriateness of the Plan of Care; and
- waiver and non-waiver providers included in the Plan of Care are delivering the services that were committed.

If a problem can not be resolved by the SAIL Personnel, then a *Grievance /Complaint* is to be filed and maintained in a Grievance and Complaint File until resolved. Each SAIL Office will maintain a Grievance and Complaint Log File. At the beginning of each new quarter in the year the team leader must send the log to the SAIL State Office for complaints made during the previous months in that quarter. A report is then forward to the Alabama Medicaid Agency LTC/QA division by the tenth day of the month following the end of the fiscal year quarter. Quarter end dates are December 31, March 31, June 30 and September 30.

The case manager is responsible for monitoring to ensure that home visits with participants are completed in a timely and efficient manner. If the participant is hospitalized at the time of the regularly scheduled visit, a follow-up made as soon as participant returns home. If the visit is not made within the month due, the case manager should telephone the participant and document in case note circumstances surrounding the missed visit. The next month's visit is made early in the following month.

**Note: Medicaid eligibility and choice of location of services must be verified and documented monthly in the narrative.**

Some participants may require more monitoring than others. Frequency of contact should be determined by prioritizing participants whose medical conditions are unstable, participants who require a complex plan of care, and/or participants who have limited support systems. This should be documented in a case note.

In home environments that have been determined to be unsafe or potentially unsafe for the case manager, a monitoring strategy should be developed. This should be documented in a case note.

### **Emergency/Disaster Protocol**

The emergency/disaster priority status for every waiver participant must be completed no later than the third visit. The case manager is responsible for initiating discussion of Emergency/Disaster Protocol in the event of an imminent disaster or notification of a participant's emergency crisis.

### **Missed PCW Visit Participant-At-Risk**

If a participant is determined by the case manager to be "at risk for a missed PCW visit," this information must be communicated to the provider at the time of the referral, and any time the status changes. The existing service contract should be sent to the provider indicating the changed status.

***"At Risk" means that the participant has no other person that can provide personal care if the worker is absent from work and his/her health is "at risk" if the service goes without provision. If the participant has back up support that can provide personal care in the event the PCW cannot go to the home, "at risk" should not be marked.***

The provider will be required to contact the case manager if services cannot be provided to the participant as authorized after backup efforts have failed. In this event, the case manager must respond immediately upon notification from the provider that the service cannot be provided. In an attempt to secure the assistance needed by the participant, efforts to secure assistance must be documented in this narrative.

### ***Missed Visits by Case Manager***

All efforts will be made to visit the participant during current eligibility month. If the case manager is unable to visit within the current eligibility month, a backup case manager will perform this visit. If the backup is unable to perform the visit, the SAIL State Office will be contacted for guidance.

### ***Service Coordination***

Service Coordination is the active, on-going process of working together with the participant and/or responsible party or knowledgeable others to assure the efficient provision of services. The case manager should constantly strive to empower the participant to become as independent as possible in advocating for him/her self and coordinating his/her own care.

The case manager should work toward developing an agreement with the participant and/or responsible party or knowledgeable others regarding the problems that exist, the goals and outcomes to be reached, and the services to be explored to reach the goals.

Through service coordination, the case manager consistently strives to meet the needs of the participant through the exploration of all formal and informal services. Coordination with formal and informal service supports are such that the absence of an authorized PCW or an emergency/disaster would have a substantial impact on the client's health and safety.

Service coordination is a vital part of developing the *Plan of Care*. The case manager works together with the participant, responsible party, and/or knowledgeable others, team members, and other involved agencies and/or parties involved in the client's care to ensure services:

- ▶ are appropriate for the participant's needs
- ▶ meet acceptable quality standards
- ▶ are not duplicated
- ▶ are cost effective alternatives
- ▶ maximize the utilization of available resources
- ▶ are provided by the agencies in accordance with maintenance of effort agreements and;
- ▶ augment, not replace, the participant's informal support system.

## **CHAPTER V – PRIOR APPROVAL PROCESS**

---

Before purchasing assistive technology (Z5322), environmental accessibility adaptations (Z5305) or PERS Installation services (Z5308), a prior approval request must be submitted to Medicaid following these procedures:

1. The case manager should obtain a written prescription from the participants physician:
  - a. when negotiating a price quote, the case manager must notify the vendor if the participant has Medicare or private insurance.

**NOTE:** *When another insurance is involved, the PA must be completed for the total cost of the equipment.*

- b. ask the vendor to file for an Explanation of Medicare Benefits which must become a part of the PA packet before payment is finalized.
2. Obtain a written quote from the vendor chosen to provide the service. The date of the price quote is the start date of service to be entered electronically on the PA. The end date spans one year from the start date of the price quote.

### **Completing the PA service item request:**

- a. If this is the first item requested, enter "1" if it is the second item requested, enter "2".
- b. Enter the start date of the PA request, which should match the date of price quote.
- c. Enter the end date of this PA request, which should correspond one year from the start date. (i.e. start date is 10/12/02 = 20021210 and end date=20031210 ). Choose the description of the services from the lookup list.
- d. Enter the number of unit of the item(s) of request.
- e. Enter the amount of the item(s) of the request for one unit.
- f. Enter the total amount or cost of the item(s).
- g. Enter a check mark for a first time PA request or *certification*.
- h. Enter a check mark if this is continuation of services previously authorized, PA request or *re-certification*.
- i. Enter date of the prescription, if of significance, listed on Form HCBS-1, p.3, with ICD 9 code from the SMILE disability lookup list.

- j. Enter a brief description of the item(s) requested to be provided and describe the impact for increasing activities of daily living skills, promoting of health and safety to the participant while in a home and community based services program.

**NOTE: *No price quote, prescription, PA approval = NO JOB. This is a fraudulent act if purchases are made contrary to guidelines.***

3. Submit the request for Prior Approval (PA) to Medicaid electronically, justifying the medical necessity for the service. Enter the service on the participant *Plan of Care*. A copy of all computerized HCBS-1 forms will be placed in the case file in the local SAIL Office.
4. Once EDS receives the PA electronically and it is accepted, a PA number will be electronically written to the request in the SMILE system. It is the case manager's responsibility to check the PA submitted periodically to obtain the PA number assigned. Once the PA number is received the case manager must fax the price quote, the prescription and any pertinent medical justification to the Prior Approval Unit at EDS. The fax number is (334) 215-4140.

Once the PA is approved, Medicaid will notify the SAIL State Office and the updates keyed into SMILE. An authorization is generated electronically by SMILE. The case manager should then notify the vendor to begin service. The authorization is then mailed to the vendor.

When a participant has private insurance/Medicare, the case manager must obtain a price quote for the total purchase price of the service. The case manager must wait for the EXPLANATION OF MEDICAL BENEFITS (EOMB) from the primary insurance source/Medicare before final payment is made to the vendor for the remaining balance of the service. The Participant's Satisfaction form must also be signed before final payment is made. A copy of the EOMB is faxed to third party billing at ADRS. The fax number (334) 293-7377.

The date that the participant signs the satisfaction form is entered as the end service date on the *Plan of Care*.

## CHAPTER VI - CHOICE OF WAIVER SERVICE PROVIDERS(s)

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

If a participant is not physically or mentally able to complete and/or sign the *Participant Choice of Provider Form*, the responsible party or other caregiver may do so for the participant. The lack of signature on the form will not preclude the participant from receiving waiver services. The participant may receive waiver services as long as a written choice is indicated on the form.

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

It is the responsibility of each District Office to keep a continuously updated list of providers for each waiver service available in that area. A copy of this list is given to each participant, responsible party, and/or knowledgeable other at each redetermination visit, so the participant will always be informed of providers serving his/her area.

At any time the participant, responsible party, and/or knowledgeable other requests an additional waiver service or a change in providers, the case manager will inform the participant, responsible party, and/or knowledgeable other of all available providers of the service(s) in question. The case manager must narrate this information exchange as well as the choice of provider(s).

Special needs of the participant, such as weekend service or specific hours of the day or evening should reflect on the Waiver contract and be documented in the narrative. These needs will be presented to the chosen provider, giving that provider the opportunity to accept or reject the referral. Because the condition of the participant 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 participant, responsible, and/or knowledgeable other) if an affirmation response has not been received from the

chosen provider within two (2) 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.

### ***Contracting for Waiver Services***

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

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

The service contract 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 contract only if the hours indicate specific times which are essential to meeting the participants' service needs. Unless specific hours are absolutely essential, rejection of a provider due to ability 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 participant. Desired hours may, of course, be negotiated with the participant and with the provider during the provider's initial contact.

### ***Verifying Implementation of Contracted Services***

Case managers must contact the participant or his/her responsible party within ten (10) working days after the service authorization start date to ensure services are implemented and to review participant/agency responsibilities. This contact may be made by telephone, home visit, or in written format. 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.

### ***Changes in services within a contracted period***

A permanent or temporary change in contracted services necessitates a revision on the service contract form. The type of change, permanent or temporary, must be indicated on the Plan of Care and documented clearly in the narrative.

A temporary change (increase in the number of units or change in authorized days) can be made for a period of thirty (30) calendar days. Any change exceeding the 30-day calendar

days must be considered permanent for the purposes of the service contract. 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 contract, which should be sent to the provider. Temporary changes should be noted on the form as a temporary change with the authorized start and end dates. The services will then revert back to the authorized service schedule as indicated on the latest service contract.

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

### ***Re-Evaluation of Waiver Services***

Re-evaluation of a waiver service occurs annually or any time that a re-evaluation 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.

### ***Interruption of PCW Services and Missed Visits***

An interruption of PCW services occurs for one of the following reasons:

- Participant enters the hospital or institution (i.e., rehabilitation center, nursing home, MR/MH facility) for a temporary stay; or
- Participant is in the community but chooses not to receive services temporarily (i.e., participant has a doctor's appointment, goes out of town, declines substitute PCW).

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

Interruptions of PCW services are reported to the local SAIL Office by the service provider on a weekly basis via the *Missed Visit and Service Interruption Report*. The case manager must document in the *Case Narrative* when the participant is hospitalized or institutionalized; narration of other interruptions in service reported by the provider is also necessary.

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

Interruption in service reported by the participant, responsible party and/or knowledgeable other (excluding calls received from providers), must be recorded on the internal *Missed Visit and Service Interruption Report form*. This includes phone calls received from the participant, responsible party, and /or knowledgeable other, as well as information obtained

by the case manager during the monitoring process. The *Internal Missed Visit and Service Interruption Report Form* serves as documentation of the internal missed visits reporting

***Direct Service Providers- Initial and Nurse Supervisory Visit Reports:***

After an individual has been accepted into the SAIL Waiver program and the participant chooses the direct service provider, the case manager is responsible for making the initial contact with the company. The direct service provider will receive a "Service Provider Contract" listing pertinent information about the SAIL participant and the contract amount of personal care ordered. Once received, the nurse should make an initial visit to the participant. The visit must be done within three (3) days of receipt of the contract and must be in accordance with the guidelines established by the Alabama Medicaid Agency.

After the initial visit has been made, the vendor will be responsible for the supervisory visit due every sixty (60)-days. A RN or LPN must perform the supervisory visits. The original of the supervisory visit report must be forwarded to the SAIL Case Manager within ten (10) days of the date of the visit. Failure to provide the documented visit will result in loss of payment from the SAIL program and repetitive non-compliance will result in loss of business with SAIL. Each participant must have a supervisory visit performed every sixty days with no exceptions. Any missed visit should be documented in the participant file and another visit scheduled within five (5) days. All supervisory visits will be performed by the RN/LPN in the participant's home. No phone calls will be accepted. The participant or a family member must sign the report indicating the visit was made in the home.

## **CHAPTER VII - CLOSURE**

---

### ***Non-Compliance:***

If a participant and/or responsible party or knowledgeable other refuses to cooperate with the SAIL Homebound Waiver Program, and all alternatives (i.e., counseling, personal contracts, referrals to interagency team staffing, case manager/supervisory visits, etc.) have been exhausted, termination of waiver services and/or termination from the Homebound Waiver Program may be appropriate.

Examples of non-compliance include but are not limited to:

- Repeated refusal to cooperate with providers and/or case managers;
- Repeated incidences of non-compliance with the *Plan of Care*.
- Physical abuse or repeated verbal abuse toward provider and/or case manager, or
- Conduct which adversely impacts the program's ability to ensure service provision or to ensure the participant's health, safety and welfare.

If termination of a waiver service for non-compliance is being considered, the following must occur:

- All efforts to work with the client/and responsible party must be documented
- Termination of service must have prior approval of State Office Program Coordinator.
- Participant must be notified of termination of service and,
- The service contract must be sent to the provider to terminate services.

If termination of the case for non-compliance is being considered, the following must occur:

- The participant and/or responsible party must be notified in writing by certified mail of the program requirements, advised of potential consequences of continued non-compliance and given an opportunity to remedy the circumstances. The letter must have State office approval prior to sending to the participant.
- All efforts to work with the participant and/or responsible party must be carefully documented; and
- Termination must be prior approved by the State Office Program Coordinator.

***Clients out of State and not expected to return:***

According to the waiver document, the client must be out of state for 60 days before SAIL can close the case. The proper documentation/procedure required that will demonstrate that services are in a "suspended status "until the closure is entered into SMILE would include:

- 1) Document that client has moved out of state with the date of the move noted.
- 2) Send e-mail or fax to Medical Supply vendor stating that client has moved out of state and service is suspended until further notice.
- 3) For Personal Care or Personal Assistance: Complete a new Service Provider Contract and send to Direct Service Provider, (DSP) This new contract should be a Discharge notice with zero hours entered and add in the comment box that states: "*Client has moved out of state. Services are being suspended until further notice by SAIL staff*".
- 4) Upon notification of the client's anticipated move, notify the company providing PERS monitoring with the planned move date and coordinate the return of the unit. Be careful not to put the client's health and safety at risk by coordinating the return of the unit too early. Make the return of the unit as close to the move date as possible.
- 5) Once the 60 days have past and if the client has not returned to Alabama do the following:
  - Close the case in SMILE
  - Notify the Medicaid District Office(DO) of the closure by fax or e-mail
  - Fax or e-mail notice of closure to the Medical Supply Vendor
  - Send a discharge Service Provider Contract to Direct Service Provider. Discharge date should always be the last day services are to be provided.

**NOTE:**

*These policies and procedures are for clients who plan to be out the State of Alabama for 60 days and closure is anticipated. If the case manager is aware that a client is going out of state temporarily on vacation and is expected to return, notify the DSP that services are being interrupted for a given time period though a fax or e-mail. This is considered a "temporary change in client's Plan of Care".*

**BE SURE TO KEEP COPIES OF ALL FAXES, E-MAILS FOR CLIENTS RECORD.**

### ***MEDICAL SUPPLIES/BILLING:***

The waiver states medical supplies are necessary to maintain the client's health, safety, and welfare and to prevent institutionalization. Supplies reimbursed with waiver funds shall be in addition to any medical supplies furnished under the State Plan and shall exclude those items which are not of direct medical or remedial benefit to the individual. These supplies do not include common over-the-counter personal care items such as mouthwash, toothpaste toothbrush, mouthwash soap, cotton swabs-Tips, etc.

All waiver medical supplies must be prescribed by a physician, be medically necessary and be specified in the Plan of Care. Case manager should at the time of new case intake or client's redetermination should always have client's doctor review, approve, and sign the List of Medical Supplies Approved for Purchased.

From time to time SAIL clients may need more medical supplies items than are provided under the Medicaid State Plan, i.e. catheters, legs bags, gloves. For those items to be paid with waiver funds, SAIL case manager must have justification why these additional supplies are needed. SAIL should never pay for medical supplies covered under the Medicaid State Plan without these justifications.

Commented [MSOffice1]: I think you still need to elaborate on reviewing the billing for accuracy and to ensure that no waiver funds are expended without justification whether state plan services or not.

### ***60 – DAY SUPERVISORY VISITS***

SAIL case managers should never pay for Personal Care Services if the 60 day supervisory visit is late from the Direct Service Provider (DSP). The DSP must have their nurse perform to visit within the required time frame and provide the supervisory visit to SAIL case manager. If a supervisory visit is late the case manger should not pay for days services were provided when DSP was out of compliance.

Commented [MSOffice2]: Need to add something about the Missed RN visits and the 5 day make up period here.

### ***DSP NOTIFYING CLIENT/FAMILY OF DATE 60 DAY SUPERVISORY VISIT***

Medicaid stated that the DSP should notify the client/family as to the day the 60 day supervisory visits is to be made, if they requested notification. However the DSP is not required to provide the client/family with the exact of time of day the visit will preformed. It is not mandatory that the DSP notify each client/family in this regard, ONLY those specifically requesting advance notification.

### ***TERMINATION OF CASES WITH REGARDS TO HEALTH AND SAFETY ISSUES:***

Waiver services can be terminated as long there is sufficient documentation showing the history and basis for the decision. This should allow the case manager to immediate terminate in the event of a health and safety issue. The termination notice to the client

## **CHAPTER VIII - SAIL WAIVER SERVICES**

---

The purpose of Waiver Services is to provide realistic options for participants who need help to remain in the home; thus avoiding unnecessary or premature nursing home care. Waiver Services are provided by qualified providers enrolled with Alabama Medicaid Agency to provide services to eligible participants.

The SAIL Case Managers must exercise maintenance of effort, which is considered to be satisfied when those agencies involved in the participant's care continue their service after Homebound Waiver becomes involved. If an agency discontinues a service, the case manager should contact that agency to determine it is a temporary or permanent interruption and then document in the narrative accordingly. Waiver Service should not be authorized until all other community resources have been explored and documented in the case narrative. For example, if a volunteer meals program is available in a community, a referral should be made to access this source. Moreover, a participant's family/or caregiver should continue their efforts in providing care for that individual. In no way should HCBS Waiver Service replace the informal caregiver's support, but should supplement their efforts.

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

***Requesting Permission to go over the capped amount on purchases for:  
Environmental Accessibility Adaptations and Assistive Technology***

Life-time caps on dollar amounts for Waiver services: Assistive Technology (AT) and Environmental Accessibility Adaptations (EAA) have been removed for approved waiver participants. In the renewal waiver document, SAIL Coordinator asked for and received a relaxation of the caps, if circumstances warranted. Alabama Medicaid Agency agreed provided SAIL Coordinator and a Medicaid Representative reviewed the request and approved of it.

The following procedure is to be used to request approval for going above the cap on items under Z5305 Environmental Accessibility and Z5322 Assistive Technology.

Prior to submitting the PA request, Case Manager will e-mail SAIL Coordinator to request exceeding the cap AT or EAA. The request must include:

- Name
- Social Security / Medicaid Number
- Item Description
- Price Quote
- Rationale (this can be copied and pasted from the PA)

SAIL Coordinator will approve, deny, or request additional information on the same e-mail. If approved, the SAIL Coordinator will document decision and forward e-mail to Medicaid PA Unit with a copy to the case manager. If denied, the SAIL Coordinator will document decision and reply to the case manager.

If additional information is needed to make a decision, the SAIL Coordinator will advise on e-mail reply.

Medicaid PA Unit, upon receipt of e-mail will review request and will approve, deny, or request additional information on the same e-mail. If approved, the Medicaid PA Unit will document decision and send e-mail reply to the case manager with a copy to the SAIL Coordinator.

If additional information is needed to make a decision, Medicaid PA unit will advise on e-mail reply with copy to SAIL Coordinator.

Once the case manager receives approval to go over the capped amount, the case manager will follow the customary steps to submit a PA request through SMILE.

This procedure is effective as of 03/11/02 to be used only for approval to go over the capped amount.

Rev. 3.24.11