

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

EDWP Service Options Using Resources in Community Environments SOURCE Case Management

DIVISION OF MEDICAID

EDWP Services Options Using Resources in Community Environments

January 1, 2023

January 1,2023 Policy Revisions included in the October 2022 Edition of the SOURCE Policy Manual

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Revision Date	Section	Revision Type	Revision Description	Citation	Reason for Change
1/1/2023	906	Add	Loss of SSI convert to 449 client transfer to CCSP.	DCH Program Policy	Align Waiver
1/1/23	906	Add	If/Then table added	DCH Program Policy	Align Waiver
1/1/23	806	Wording changed	Change to RN signature can be added next business day after Medical Director signature.	DCH Program Policy	Align Waiver
				DCH Program Policy	Align Waiver
				DCH Program Policy	Align Waiver
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				DCH Program Policy	Align Waiver
				DCH Program Policy	Align Waiver
				DCH Program Policy	Align Waiver
				DCH Program Policy	Align with waiver
				DCH Program Policy	

October 1,2022 Policy Revisions included in the July 2022 Edition of the SOURCE Policy Manual

Revision Date	Section	Revision Type	Revision Description	Citation	Reason for Change
10/1/2022	903	Add	Add Medication list to #7 and Routine Admission overview	DCH Program Policy	Align Waiver
10/1/2022	1100 h	Add	Medication list to be maintained in provider records	DCH Program Policy	Align Waiver
10/1/2022	1302 #1 d	Add	Medication List	DCH Program Policy	Align Waiver
				DCH Program Policy	Align Waiver
				DCH Program Policy	Align Waiver
				DCH Program Policy	Align Waiver
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				DCH Program Policy	Align Waiver
				DCH Program Policy	Align Waiver
				DCH Program Policy	Align with waiver
				DCH Program Policy	

July1,2022 Policy Revisions included in the April 2022 Edition of the SOURCE Policy Manual

Revision Date	Section	Revision Type	Revision Description	Citation	Reason for Change
7/1/2022	Entire Manual	Change	All 200 references to Care Path or carepath have been changed to Care Plan	DCH Program Policy	Align Waiver
7/1/2022	Preface	Removed	Removed Abbreviations associated with the Carepath	DCH Program Policy	Align Waiver
7/1/2022	603 - 2	Changed	To individualized care plans under Core Refinements	DCH Program Policy	Align Waiver
7/1/2022	801 G	Removed	Removed line regarding a less than one year LOC	DCH Program Policy	Align Waiver
7/1/2022	806	Changed	Changed wording to remove sign care plan to MD and RN sign LOC page	DCH Program Policy	Align Waiver
7/1/2022	902	Changed	Removed Carepath add Care Plan and task lists	DCH Program Policy	Align Waiver
7/1/2022	902 J	Add	Add SFC Evaluation and Caregiver Attestation Form	DCH Program Policy	Align Waiver
7/1/2022	903 A 7	Change	Remove Referral Form and EDWP Notification add Service Order, Discharge Form and Emergency Disaster Form	DCH Program Policy	Align Waiver
7/1/2022	903	Change	Revised Note to 7/22 Change to Change In Service Letter for physician approve of any change in service	DCH Program Policy	Align Waiver
7/1/2022	903 B	Change	Member 5389 and SOURCE Service Order	DCH Program Policy	Align Waiver
7/1/2022	903 C	Add	Add to Alliant upload Demographics and any advanced assessments done	DCH Program Policy	Align Waiver
7/1/2022	904-8	Removed	Member Referral form and EDWP Notification form	DCH Program Policy	Align Waiver

7/1/2022	904-8	Add	Demographics, Discharge Form, and Disaster Emergency Form	DCH Program Policy	Align Waiver
7/1/2022	905	Remove	Reference to signature page of care path and change to use of Change In Service Letter for MD signature	DCH Program Policy	Align Waiver
7/1/2022	905	Add	Add Care Plan, Service Order, and Task Lists	DCH Program Policy	Align Waiver
7/1/2022	906	Add	Add to contact lead for acceptance before transfer	DCH Program Policy	Align Waiver
7/1/2022	1001	Add	Emergency Disaster Plan	DCH Program Policy	Align Waiver
7/1/2022	1002	Change	Remove Physician Signature and add Change In Service letter for the Medical Director to sign throughout.	DCH Program Policy	Align Waiver
7/1/2022	1003	Change	Review Care Plan and Task lists with member	DCH Program Policy	Align Waiver
7/1/2022	1004 and 1005	Removed	Member Version and Formal Review sections removed from policy	DCH Program Policy	Align Waiver
7/1/2022	1100 E & F	Change	Change Referral Form to Service Order	DCH Program Policy	Align Waiver
7/1/2022	1100 H	Add	Add Discharge Form, Emergency Disaster form and Demographics	DCH Program Policy	Align Waiver
7/1/2022	1100 K 2	Add	Forward copy of the care plan, task lists, and evaluations to provider	DCH Program Policy	Align Waiver
7/1/2022	1200 C 1 & 2	Add	Care Plan, Task lists, Task Evaluations and Care Notes	DCH Program Policy	Align Waiver
7/1/2022	1302 A	Removed	Remove Referral Form and remove 10 day contact.	DCH Program Policy	Align Waiver
7/1/2022	1302 C	Removed	Removed Reference of Member Version	DCH Program Policy	Align Waiver

7/1/2022	1302 D	Removed	Removed 8, 9, and 10	DCH Program Policy	Align Waiver
7/1/2022	1306 1307	Add	Add verbiage that makes it PRN	DCH Program Policy	Align Waiver
7/1/2022	1308	Removed	1308 Removed from policy	DCH Program Policy	Align Waiver
7/1/2022	1309	Removed	Removed PCP paragraph, wording on line 7, and line 10, 11,12 removed	DCH Program Policy	Align Waiver
7/1/2022	1400	Removed	Care Plan Formal Review. Removed monitoring of PCP and HCBS services	DCH Program Policy	Align Waiver
7/1/2022	1401	Change	Removed Referral Form and add Service Order	DCH Program Policy	Align Waiver
7/1/2022	1403	Removed	Removed from Health System Linkages	DCH Program Policy	Align Waiver
7/1/2022	1404	Remove	Remove line that CM is to discharge the member's PCP	DCH Program Policy	Align Waiver
7/1/2022	1405	Change	To add Service Order and Task lists	DCH Program Policy	Align Waiver
7/1/2022	1416	Added	Standards of Promptness	DCH Program Policy	Align Waiver

April 1,2022 Policy Revisions included in the January 2022 Edition of the SOURCE Policy Manual

Revision Date	Section	Revision Type	Revision Description	Citation	Reason for Change
4/1/2022	All	Removal	All references to the Assessment Addendum(optional) have been removed from policy.	DCH Program Policy	Align Waiver
				DCH Program Policy	Align Waiver
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				DCH Program Policy	Align with waiver
				DCH Program Policy	

January 1,2022 Policy Revisions included in the October 2021 Edition of the SOURCE Policy Manual

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Revision Date	Section	Revision Type	Revision Description	Citation	Reason for Change
1/1/22	906	Add to policy	Added new Transfer Form Supplement checklist to be sent to DCH with each transfer.	DCH Program Policy	Align Waiver
1/1/22	1405	Change	Do not send DC to Alliant, leave LOC PA open until it expires.	DCH Program Policy	Align Waiver
				DCH Program Policy	Align Waiver
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				DCH Program Policy	Align with waiver
				DCH Program Policy	

October 1,2021 Policy Revisions included in the July 2021 Edition of the SOURCE Policy Manual

Revision Date	Section	Revision Type	Revision Description	Citation	Reason for Change
10/1/2021	901	Add wording to Procedure G Form change	Appendix Z removed from forms manual and If not eligible for SOURCE at screening use the Notice of Denial of LOC Elderly and Disabled Waiver Letter	DCH Program Policy	Align Waiver
10/1/2021	1404	Form changed for discharge from SOURCE	Member Discharge procedure #7, for any reason other than Level of Care will use the Elderly and Disabled Discharge Form 5382 to notify the member.	DCH Program Policy	Align Waiver
10/1/2021	1405	Form changed for Appealing Denials	Member has form 5382 for Involuntary Discharges as well as Voluntary	DCH Program Policy	Align Waiver
10/1/2021	1406	Form changed for Appealing	Member has for 5381 to Appeal any adverse action by case management	DCH Program Policy	Align Waiver
10/1/2021	1409	Removed	Removed section regarding preferred providers and SOURCE ability to discharge from program.	DCH Program Policy	Align Waiver
10/1/2021	701	Added Note	Not eligible if only needs HDM and case Management. HDM can not stand alone	DCH Program Policy	Align Waiver
10/1/2021	804	Wording	Removed National finger-print and changed wording to align with EDWP and Part I Medicaid	DCH Program Policy	Align Waiver
				DCH Program Policy	Align Waiver
				DCH Program Policy	Align Waiver
				DCH Program Policy	Align Waiver
				DCH Program Policy	Align with waiver
				DCH Program Policy	

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Part II Policies and Procedures Manual for SOURCE Services

PREFACE

The policies, procedures and definitions detailed and explained in this manual apply to all SOURCE Case Management Providers.

Unless otherwise indicated by the SOURCE DCH Policy and Procedure Manual, all service providers must refer to Community Care Services Program for program requirements about policies and procedures specific to each service type.

Part II	Chapter 1100	Adult Day Health
Part II	Chapter 1200	Alternative Living Services
Part II	Chapter 1300	Home Delivered Services
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Part II	Chapter 1500	Out-of-Home Respite Care
Part II	Chapter 1600	Emergency Response
Part II	Chapter 1700	Home Delivered Meals

Unless otherwise indicated by the SOURCE Policy and Procedure Manual, all SOURCE Case Management Providers and service providers are required to strictly adhere to Part I – Policies and Procedures Applicable to All Medicaid Providers.

SOURCE Definitions/Abbreviations

As used in this policy manual, unless the content indicates otherwise, the term:

Activities of Daily Living (ADLs) – include fundamental activities related to community living, such as eating, bathing/dressing, grooming, transferring/locomotion and toileting.

Caregiver (CG) – Person providing significant non-paid support to a SOURCE member; most typically a family member. Has formal or informal authority to receive information and participate in decision –making on behalf of a SOURCE member.

Care Plan – An individualized plan of care for each member to address care needs and set goals for the care needs. SOURCE Care Plans address risk factors associated with chronic illness and functional impairment.

Care Plan Variance – When an expected Care Plan outcome doesn't occur; a Care plan goal not met. Variances require action on the part of the Case Manager to ensure that issues are promptly resolved, and goals will be met in the following review period.

Case Management Supervisor (CM Supervisor) – The staff member with direct supervisory authority over Case Managers; may also serve as Program Manager. Responsible for ensuring that CMs address Care plan variances and work in accordance with program goals. Assists CM in problem solving, reviews documentation and monitors provider performance.

Case Manager (CM) – The staff person serving as the SOURCE member's liaison and representative with other program key players; the CM's primary responsibility is to ensure that goals of the program and of individual members are met. Performs functions of needs assessment, Care plan monitoring and coordination with other health system or social service personnel.

Case Note – An entry in a SOURCE member's chart by a Case Manager or Case Management Supervisor. Case notes document contacts with or on behalf of SOURCE members; actions taken on behalf of SOURCE members; or observations/follow-up planning by case management staff. Case notes should give the date, the person contacted, the setting and a description of the exchange. Case notes are used to note problems identified, to document resulting follow-up activity and to indicate when problems are resolved. Notes written on SOURCE Contact Sheets are considered case notes.

Community Care Services Program (CCSP) – Medicaid funded program in Georgia providing a range of community-based services to nursing home eligible persons, administered by the state's Department of Human Resources under a 1915 (c) waiver.

Community Services – The menu of possible services reimbursed through SOURCE according to the care plan authorized by the site, provided in a home or community setting.

Community Service Provider – An organization participating in the program as a provider of community services authorized by the CM and reimbursed through SOURCE

Concurrent Review-The process of regular and thorough review of essential information about individual SOURCE members, by a Case Manager and key players; used to ensure that Care plan and program goals are met.

Conflict Free Case Management- restricts the delivery of Case Management Support and Home and Community Based Direct Services by the same agency or entity.

DON-R- The Screening tool entitled Determination of Need- Revised**.**

Enhanced Primary Care Case Management – The service provided through the SOURCE program, blending primary medical care with case management and community services for Medicaid recipients with chronic illness.

AHS- Alliant Health Solutions, medical management vendor, subcontractor of DCH.

SOURCE Definitions/Abbreviations

MDS-HC – Minimum Data Set Health Care – A Home and Community standardized assessment tool to determine Level of Care. SOURCE program uses Version 9.

Medicaid – A jointly funded, federal/state healthcare assistance program administered by the Division of Medical Assistance (DMA) under the Georgia Department of Community Health, serving primarily low- income individuals: children, pregnant women, the elderly, and the blind and disabled. SOURCE falls under DMA's Aging and Community Services.

Medical Director – A Medical Director is a physician, Nurse Practitioner, or PA who oversees the medical care and other.

Home and Community Based Services (HCBS) – Supportive services delivered in a home or community setting, as opposed to a nursing home or other institution. Personal care services and home delivered meals are examples of HCBS. In addition to a private residence, HCBS settings also include personal care homes and adult day health centers.

Instrumental Activities of Daily Living (IADLs) – include supportive activities related to community living, such as meal preparation, housekeeping, using the telephone, financial management, etc.

Key Players – Individuals or organizations bearing major responsibility for ensuring that program and Care plan goals are met: SOURCE members and/or informal caregivers, Case Managers, CM Supervisors, Medical Director, PCPs, and service providers.

EDWP Notification Form (ENF) – Form used to record communication between SOURCE Case Management Provider and the service providers. Required for documenting key exchanges (service level changes, etc.), the ENF may be initiated by either party.

Program Manager – The staff member responsible for ensuring proper implementation of all policies and procedures of the SOURCE program. Primary responsibilities include coordination among key players, developing site-specific policies and procedures, leading data analysis and serving as liaison with the Department of Community Health.

SOURCE Level of Care and Placement Instrument – Document used to formally enroll Medicaid members into the SOURCE program.

SOURCE Member – A Medicaid recipient who is formally enrolled in the SOURCE Enhanced Primary Care Case Management program.

Primary Care Provider (PCP) – The chief clinical partner in providing enhanced case management to SOURCE members; may be a physician or a nurse practitioner. Responsibilities include direct **primary** medical care and coordinating with other key players in the program. All SOURCE members must be under the care of a PCP of their choice

SOURCE Enhanced Case Management – The entity under contract with the Georgia Department of Community Health, Division of Medical Assistance, to provide the "enhanced primary care case management" service described in this manual and in the SOURCE Memorandum of Understanding. Program components may be provided directly by the entity holding the contract or by sub-contract, but the site bears responsibility for implementation of program policies and procedures.

PART II - CHAPTER 600

SOURCE OVERVIEW

601. Introduction to SOURCE

SOURCE operates under authority of the Elderly and Disabled 1915-c Home and Community Based Services (HCBSS) Medicaid Waiver approved by the Centers for Medicare and Medicaid Services (CMS).

Individuals eligible for enrollment in SOURCE must be eligible for full Medicaid (this excludes SLMB, QMB, and QI). Individuals served by SOURCE must be physically **impaired**, functionally impaired and in need of services to assist with the performance of activities of daily living (ADLs). Without waiver services, eligible SOURCE members would require placement in a nursing facility. While individuals, participating in SOURCE under the Elderly and Disabled waiver, do not have specific exclusions related to age, the SOURCE waiver targets individuals who are elderly and physically disabled.

Through the Enhanced Primary Care Case Management (EPCCM) model, SOURCE links primary care to community services. The model is comprised of three principal components – primary medical care, community services and case management -integrated by the site's authority to approve Medicaid-reimbursed services.

SOURCE sites receive an enhanced case management fee per member per month.

Community and physician services for SOURCE members are covered under conventional Medicaid fee-for-service reimbursement with authorization by the site. For dually insured members, Medicare remains the primary payer for services traditionally covered by Medicare. While the SOURCE Case Management Provider is expected to coordinate services delivered under Medicare, no authorization is required for Medicare reimbursement. For services covered by Medicaid, in addition to community and physician services (hospitalizations, lab/diagnostics, co-pays for dually insured members, etc.), the SOURCE Enhanced Case Management authorization number may be required.

602. SOURCE Goals

Goals identified for SOURCE include:

a) Reducing the need for long-term institutional placement and increasing options in the community for older and disabled Georgians, by designing an effective model replicable across the state

b) Preventing the level of disability and disease from increasing in members with chronic illness

c) Eliminating fragmented service delivery through coordination of medical and long-term support services

d) Increasing the cost-efficiency and value of Medicaid Long Term Care (LTC) funds by reducing inappropriate emergency room use, multiple hospitalizations and nursing home placement caused by preventable medical complications; also by promoting self-care and informal support when possible for individual members

603. Core Refinements to Traditional HCBS

The SOURCE Program implements three (3) core refinements to traditional HCBS programs:

1) SOURCE financially and operationally integrates primary medical care with the case management of home and community-based services.

2) SOURCE develops individualized Care Plans for chronically ill persons (targeting conditions such as diabetes, high blood pressure, Alzheimer's Disease, dementia, stroke, heart disease, asthma or other pulmonary conditions)

Care Plans constitute a structured case management accountability system that regularly measures the achievement of key objectives for individual members, for the caseload of each Case Manager or Primary Care Provider and for the entire program.

3) SOURCE measures the performance of Case Management Agencies and providers of community services by standards that exceed basic licensing requirements. Case Management Agencies and Providers of personal/extended support services (the most highly accessed category of service) will honor member and program expectations of:

Reliability of service, including early morning or late evening visits/care Adequate, Competent, Consistent, Compatible staffing

Responsiveness to member and staff concerns, including the scope of care as described by the member or caregiver

Coordination --with Case Managers for the community service providers and Other Agencies for the Case Management Agencies

The Case Management and provider's role in achieving care plan objectives – including member satisfaction with services – is regularly measured, addressed with performance improvement strategies as indicated and used to determine case assignments.

604. SOURCE Themes

The SOURCE vision of an ethical and disciplined community-based long-term care system is described by several key themes that apply broadly to all members in the program (sites, members, providers, DMA):

a) Integration:

Empowerment via the authority to enforce expectations of key players by authorizing payments
Communication – scheduled and as needed to meet individual and program goals
Common objectives that keep members at the center

b) Member centered approach:

Member/family contribution and cooperation encouraged and valued
Advocacy for individual members, across all settings
Inclusiveness of varying ages, disabilities and functional capacities

c) Continuous improvement:

Collecting and reviewing data regularly to identify problem areas
Marshalling resources to help individuals address problems
Redesigning systems to help DCH address problems for chronic care populations

605. Partnership with DCH

All sites will maintain a partnership with DCH to continuously improve overall program performance and to ensure that individual sites are working toward stated goals.

This partnership may be fulfilled by sites in several ways**:**

a) Participation at scheduled meetings with DCH staff to discuss program guidelines, performance improvement strategies and site-specific updates.

b) Monthly reporting to DCH on program activity due on the 15th of the month following the reporting period
c) Compliance with quality assurance protocols for waiver programs developed for CMS by DCH

DCH maintains oversight of all program components and reserves the right to grant final approval of all aspects of the program including, but not limited to, determination of eligibility and ILOC.

606. Enrolling as a SOURCE Enhanced Case Management Provider

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

Upon completion of the steps below by the Case Management agency, a site visit of the applicant's agency will be performed by DCH as well as completion of mandatory training of policy before a member referral can begin. Initial and expansion application territory requests are limited to a maximum of ten (10) counties.

All applicant's companies must provide all of the following:

a) Proof of experience in case management for a minimum of twenty-four (24) months prior to making application for enrollment.

b) Case Management- Initial and annual assessment, care plan development and monitoring, working with other service providers, financial responsibility management etc.

c) Proof of business management experience, managing five (5) or more employees, in the health care field, for a minimum of twelve (12) consecutive months prior to making application for enrollment.

d) Proof of assurance of conflict free case management.

e) Information regarding the Medical Director in the Enhanced Case Management option, providing a written agreement with the person chosen for that position. If a NP or PA is contracted, the physician who supervises them is also required to send license copy. Provide the RN license that will be providing assessments

f) Organizational chart for the agency that includes all related positions with clear lines of authority. Submit job descriptions for all positions as well as resumes, documenting the number of staff members in each position.

g) Normal operating hours and days for the office. Describe how a 24-hour a day/seven (7) days per week/three hundred sixty-five (365) days per year on-call system will be maintained. Describe how the timeliness to calls and response to problems will be documented and reviewed.

h) Documentation of service provider list for new clients entering the program to choose from.

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

j) Description of who will be responsible for billing Medicaid for the Case Management fee and the process for oversight of billing.

k) Demonstration of maintenance of a satisfactory record of compliance with federal and state laws

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

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

In addition, the provider agency must have had no deficiencies within the past three (3) years from any licensing, funding, or regulatory entity associated with enrollment in any Medicaid services, or with the provision of any related business, unless, such deficiencies has been corrected to the satisfaction of the imposing entity and DCH.

If applicable, DCH may conduct site visits with an applicant provider agency. Should the DCH site visit results in unsatisfactory review, DCH will deny the enrollment application.

Additionally, all Case Management agencies will submit a Business Plan to the following address:

Department of Community Health
Long Term Care Section
2 Peachtree St. NW
37th Floor
Atlanta, Georgia 30303

Application access is via the 'Enrollment Wizard' under the "Provider Enrollment" menu at www.mmis.georgia.gov.

NOTE: If the applicant is denied, DCH will notify the applicant agency of the reason for the denial. Applicant agencies have the right to appeal enrollment denial as indicated in Part I, Policies and Procedures for Medicaid/Peachcare for Kids Manual. An applicant may not re-apply for one (1) year after date of denial.

607. Expansion Procedures

All previously approved by SOURCE Enhanced Primary Care Case Management (EPCCM) must submit an expansion application to the Department of Community Health for review and approval prior to the opening any new office or expansions into additional counties by an existing office.

If you plan to expand and existing office into additional counties, you are required to submit a business plan with your list of the counties to be served by the current office, A detailed list of the specific of the counties that would ~~to~~ be served by the expansion and a demographics that support and document an unmet need for SOURCE services in the areas proposed to be served.

If there is to be a new office established as part of for your expansion, please send the following information:

1) The name, telephone number and email for the contact person for the application.

2) The full address of the new office location, telephone number, and email for the new office.

3) Days and hours of operation for the new office.

4) A detailed list of the specific~~ation~~ of the counties that would ~~to~~ be served by the new office.

5) Demographics that support and document an unmet need for SOURCE services in the areas proposed to be served.

6) Documentation that the applicant has a written agreement with a physician, NP, or PA to be the Medical Director for the new office. Include Medical Director Resume. Include the physician's license if Medical Director is a NP or PA.

7) A staffing plan, including an organization chart, for the new office that documents it will be adequately staffed to meet the requirements for the case manager and case management functions.

8) Written job descriptions for all positions in the new office.

9) An organization chart delineating the relationship of the new office to the previously approved SOURCE site that documents adequate oversight by the SOURCE site for the new office.

10) Copies of site-specific policies and procedures for screening, assessment, admissions, Care Plan development and implementation, referral for HCBS services, member contacts (scheduled and PRN), provider contacts (scheduled and PRN), disease management, HIPAA compliance, appeals, and measures to meet unfunded member needs.

    Please Note: The policies and procedures must be site specific. Do not submit copies of the policies in the SOURCE manual. If the site has previously submitted all of the above policies and none has changed since the last submission, the site may state that and simply refer to its initial submission.

There will be an audit requirement for any Case Management agency that requests an expansion of their service area.

Any negative audit could result in a denial of the agency expansion plan and a ban on new admissions could be applied as corrective action until the agency proves it is complaint.

Providers seeking expansion are required to be compliant with all applicable laws, rules, regulations, policies and procedures of all services the provider is currently enrolled to provide. DCH will not process an expansion request for a provider against whom there are unresolved complaints/deficiencies cited by Utilization Review/ Program Integrity or other licensing or regulatory agencies.

608. Community Service Provider Enrollment Procedure

To become a SOURCE community service provider, please refer to the CCSP General Services Manual, sections 601.1 and 601.2 for qualifications and new provider enrollment information. If currently a CCSP provider, then please contact the Provider Specialist with DCH at ccsp.messages@dch.ga.gov.

701 Eligible Members

SOURCE operates undue the authority of the Georgia Elderly and Disabled 1915c Medicaid Waver. For core waiver requirements see section 801.3.

The target population for SOURCE are physically disabled individuals who are functionally impaired, or who have acquired a cognitive loss, that results in the need for assistance in the performance of the activities of daily living (ADLs) and instrumental activities of daily living (IADLs); these individuals must meet the Definition for

Intermediate Nursing Home Level of Care (LOC). Eligibility factors must be met annually or more often per guidelines in this manual, referenced manuals and the federal Waiver.

a) Aged 65 and older, or under 65 and physically disabled
b) Receiving full Medicaid (this excludes SLMB, QMB, QI)
c) Eligible based on meeting criteria for Intermediate Nursing Home Level of Care
d) Cost of necessary services can be provided by SOURCE at less cost than the Medicaid cost of nursing facility care
e) Willing participants who choose enrollment in the SOURCE Program (Member choice)
f) Residing in a SOURCE Enhanced Case Management's designated service area; and
g) Capable, with assistance from SOURCE and/or informal caregivers, of safely residing in the community (with consideration for a recipient's right to take calculated risks in how and where he or she lives) calculated risks in how and where he or she lives)

Note: Home Delivered Meals and Case Management combined is not the only service need

NOTE: Medicaid eligible members under the age of twenty-one (21) will be referred to Medicaid's GAPP (Georgia Pediatric Program) to be screened for the Medicaid's State Plan services. Any service request for those under 21 that is not covered in the State Plan under GAPP or Autism Spectrum Disorder Services can be referred for screening and eligibility determination of the requested service. As the Department moves to evaluate children on the waiver and compliance with federal mandates, continuity of care will be the first concern.

Member General Exclusions

- Members currently enrolled as members in the Georgia Families program (this is not the Georgia 360^0 program)
- Members with retroactive eligibility only and members with presumptive eligibility
- Children with severe emotional disturbances whose care is coordinated under the PRTF program
- Members of a federally- recognized Indian Tribe
- Qualified Medicare Beneficiaries (QMBs) without SSI (or full Medicaid);
- SLMB or QI without SSI (or full Medicaid)
- Members Residing in an Institution
- Members not meeting eligibility requirements
- Programs or Waivers that would cause duplication or services*

***Dual Waiver Enrollment Exclusions and Allowances:**

In some instances, SOURCE members are allowed to participate in more than one waiver or program. There are still some Waiver and program exclusions. In the instance where a member would need to choose, individuals have the option of transfer from one waiver to another, contingent upon eligibility and available funding.

Exclusions from enrolling in two Waivers/Programs:

A member enrolled in SOURCE cannot receive duplicate services. Medicaid Waiver Programs that would

cause duplication of services or excluded.

Waivers or programs where the member would need to be enrolled as an inpatient/ or in an institution are excluded from SOURCE.
All members considered for SOURCE must meet all SOURCE eligibility requirements.

Examples of Exclusions:

- Members who are, at the time of application for enrollment or at the time of enrollment, domiciled or residing in an institution, including skilled nursing facilities, hospital swing bed units, hospice inpatient, intermediate care facilities for people with developmental disabilities, or correctional institutions

- CCSP, Independent Care Waiver, the NOW and COMP Waiver Programs members are excluded

Allowances

The SOURCE agency continues to assume full responsibility for the professional management of the individual's SOURCE care in accordance with the SOURCE manual. When an individual enrolled in SOURCE elects a second program or when an individual in another non-excluded program elects SOURCE: See lists below for allowances

SOURCE dual enrollment in GAPP may be permitted
Please refer to the GAPP manual for more information

SOURCE dual enrollment in Hospice may be permitted without duplication of services.

PSS services and Skilled Nursing are not a covered service from the SOURCE provider. *An individual or a child currently enrolled in a Medicaid waiver program that is diagnosed with a terminal illness may elect to enroll in the Hospice program. Please see Community Care Services General Manual section 901 Covered Services for more information*

Children Receiving Services under Title V/CMS without duplication of Services may be permitted
Caution should be given for children in this category, member must demonstrate all eligibility requirements including a need for SOURCE services.

Procedure for Dual Enrollment:

If dual enrollment is desired by the member and meets the guidelines above (and of course all eligibility requirements) the agency should follow these procedures:

A. The member's SOURCE team and the 2nd program's case manager and member **must** communicate, establish, and agree upon a coordinated plan of care for both providers that prevents duplication of services. Distinct Case management services must be agreed upon to be given by each CM agency. Information on these areas is documented at the beginning of the relationship and quarterly. More frequent communication should be documented if the need arises.

B. Both companies must keep records that indicate that multiple Medicaid plans of care have been coordinated. Failure to demonstrate this coordination will be considered a failure to comply with the terms of this policy. As such, lack of evidence of coordinated care in documentation will result in a terminated lock-in and any paid claims for services will be subject to recoupment.

C. If Hospice is the designated 2nd program, the hospice agency MUST be the provider of the skilled nursing and personal support services. SOURCE may provide extended personal support services (in-home respite). If SOURCE member is in a PCH, the PCH must continue to give all care and not designate the normal care of a member to the Waiver such as hospice

D. All hospice services must continue to be provided directly by hospice employees. The services cannot be delegated. When the member is in a waiver program residential facility (SOURCE Personal Care Home), the hospice agency may involve the facility staff in assisting the administration of prescribed therapies that are included in the plan of care; this is only to the extent that the hospice would routinely utilize the service of the patient's family/caregiver in implementing the plan of care.

E. When the member is a resident in a waiver program's residential facility, the facility must continue to offer the same services to the individual that elects the hospice benefit. The hospice member should not experience any lack of facility services because of his/her status as a hospice member.

The following activities are not allowed by SOURCE providers of any type:

SOLICITATION OF MEMBERS FOR THE SOURCE PROGRAM
This includes:

- Developing care plans, using amount or frequency of services, to encourage member choice of providers
- Soliciting clients from other providers or other programs

Neither SOURCE case management providers nor HBCS providers shall solicit Medicaid members for the purpose of rendering SOURCE services, following the policy outlined in:
Part I, Policies and Procedures for Medicaid/Peachcare for Kids-- which all Medicaid providers agree to follow. The policy states:

106. General Conditions of Participation

> Not contact, provide gratuities or advertise "free" services to Medicaid or PeachCare for Kids members for the purpose of soliciting members' requests for services. Any activity such as obtaining a list of Medicaid or PeachCare for Kids members or canvassing neighborhoods (or offices) for direct contact with Medicaid or PeachCare for Kids members is prohibited. Any offer or payment of remuneration, whether direct, indirect, overt, covert, in cash or in kind, in return for the referral of a Medicaid or PeachCare for Kids member is also prohibited. It is not the intent of this provision to interfere with the normal pattern of quality medical care that results in follow-up treatment. Direct contact of patients for follow-up visits is not considered solicitation, nor is an acknowledgment that the provider accepts Medicaid/PeachCare for Kids patients.

801 Levels of Care

Level of Care Criteria

a) The Intermediate Level of Care (LOC) determination for SOURCE is based on: the medical criteria used by Department of Community Health (DCH), Division of Medicaid to establish an individual's LOC certification for nursing facility placement. SOURCE members must meet the Level of Care criteria for Intermediate Nursing Home Placement (see 801.3). Level of care determination is a function of the assessment process which includes: the SOURCE RN/LPN, using the MDS-HC (v-9), Level of Care criteria, and professional judgment, giving a preliminary determination of Level of Care (LOC) for members during the assessment process.
b) AHS or DCH gives final approval on all members for an active Level of Care.
c) Assessments and re-assessments completed by the LPN **must** be signed and certified by the designated RN within 10 business days of completion.
d) SOURCE services rendered to a member will be ordered by a physician and listed on the Care plan and SOURCE Level of Care and Placement Instrument with the Primary Care Physician/Medical Director's signature on the orders.
e) Providers may render SOURCE Services only to members with a current LOC as reflected on current SOURCE Level of Care and Placement Instrument, approved by AHS (all members as of 9/30/2013), and affirmed by the completed MDS-HC (v9) assessment.
f) Members must meet all SOURCE eligibility criteria to participate in the program.
g) Each qualifying SOURCE member is given an approved LOC certification for SOURCE program participation by AHS. A LOC certification is approved for no more than 12 months (usually 365 days).
h) The AHS Prior Authorization effective date is to be the LOS start date on the SOURCE Level of Care and Placement Instrument LOC form, the AHS expiration date is to be the LOS end date.
i) Effective with SOURCE Initial Assessments conducted on March 1,2018 or after, the approved length of stay will begin with the day the assessment is conducted. This will allow case management to be covered under a length of stay for a level of care from the date of the assessment. This cannot be billed until the Level of Care has been determined by AHS and attestation of the Medical Director and RN.

Note: DCH maintains oversight of all program components and reserves the right to give final approval on all aspects of the program including eligibility and ILOC. DCH may extend LOC with legal documents or provisional level of care document. This may be especially necessary during the months when transitioning from MMIS locks to Prior Approval system.

801.3 For Source, the eligible individual will meet the target population guidelines and Intermediate Nursing Home LOC:

The target population for SOURCE is physically disabled individuals who are functionally impaired or who have acquired a cognitive loss that results in need of services to assist with the performance of the activities of daily living (ADLs). All individuals must meet the Definition for Intermediate Nursing Home LEVEL OF CARE:

Summary for Intermediate Nursing home LEVEL OF CARE CRITERIA and SOURCE Program guidelines:

1. Services may be provided to an individual with a stable medical condition requiring intermittent skilled nursing services under the direction of a licensed physician (Column A Medical Status) AND either a mental/ cognitive (column B) and/or functional impairment that would prevent self-execution of the required nursing care (Column C Functional Status).

2. Special attention should be given to cases where psychiatric treatment is involved. A patient is not considered appropriate for intermediate care services when the primary diagnosis or the primary needs of the patient are psychiatric or related to a developmental disability rather than medical need. This individual must also have medical care needs that meet the criteria for intermediate care facility placement. In some cases, a patient suffering from mental illness may need the type of services which constitute intermediate care because the mental condition is secondary to another more acute medical disorder.

Use the following table to assist with SOURCE Level of Care and Placement Instrument and I for SOURCE clients:

To meet an intermediate nursing home level of care the individual must meet item # 1 in Column A AND one other item in Column A, PLUS at least one item from Column B or C (with the exception of #5, Column C)

Items are interpretive guidelines for SOURCE eligibility.

COLUMN A Medical Status	**COLUMN B** Mental Status (must include a cognitive loss) rev. 04/11 Mental Status impairment with etiologic diagnosis not related to a developmental disability or mental illness The mental status must be such that the cognitive loss is more than occasional forgetfulness	**COLUMN C** Functional Status impairment with etiologic diagnosis not related to a developmental disability or mental illness
1. Requires monitoring and overall management of a medical condition(s) under the direction of a licensed physician. In addition to the criteria listed immediately above, the patient's specific medical condition must require any of the following (2-8), plus one item from Column B or C. 2. Nutritional management; which may include therapeutic diets or maintenance of hydration status. 3. Maintenance and preventive skin care and treatment of skin conditions, such as cuts, abrasions, or healing decubiti. 4. Catheter care such as catheter change and irrigation. 5. Therapy services such as oxygen therapy, physical therapy, speech therapy, occupational therapy (less than five (5) times weekly for SOURCE). 6. Restorative nursing services such as range of motion exercises and bowel and bladder training. 7. Monitoring of vital signs and laboratory studies or weights. 8. Management and administration of medications including injections.	1. Documented short or long-term memory deficits with etiologic diagnosis such that it interferes significantly with the activities of daily living. Cognitive loss must also be addressed on MDS/care plan for continued placement. 2. Documented moderately or severely impaired cognitive skills with etiologic diagnosis as above for daily decision making such that it interferes significantly with the activities of daily living. Cognitive loss addressed on MDS/care plan for continued placement. 3. Problem behavior, i.e., wandering, verbal abuse, physically and/or socially disruptive or inappropriate behavior requiring appropriate supervision or intervention such that it interferes significantly with the activities of daily living. Cognitive loss must also be addressed. 4. Undetermined cognitive patterns which cannot be assessed by a mental status exam, for example, due to aphasia such that it interferes significantly with the activities of daily living. Cognitive loss must also be addressed.	1. Transfer and locomotion performance of resident requires limited/extensive assistance by staff through help or one-person physical assist. 2. Assistance with feeding. Continuous stand-by supervision, encouragement or cueing required and set-up help of meals. 3. Requires direct assistance of another person to maintain continence. 4. Documented communication deficits in making self- understood or understanding others. Deficits must be addressed in medical record with etiologic diagnosis addressed on MDS/care plan for continued placement. 5. Direct stand-by supervision or cueing with one-person physical assistance from staff to complete dressing and personal hygiene. (If this is the only evaluation of care identified, another deficit in functional status is required).

PROCEDURES ONCE 'SLOT' IS AVAILABLE FOR MEMBER:

1) Complete MDS-HC with member
2) Obtain member signature on the SOURCE Level of Care and Placement Form
3) Upload required material requested by AHS to AHS via web portal.
4) If AHS validates Level of Care then give the entire packet to the multidisciplinary team meeting with the Medical Director who will sign

802 Primary Medical Care

SOURCE Case Management Provider Case Managers work with member's primary care provider on meeting program goals for members. Providers include physicians, (e.g. Internal Medicine, Family Practice and geriatricians), and nurse practitioners.

In addition to traditional functions of evaluation/ treatment for episodic illness and minor injury, key features of SOURCE primary care are:

Initial visit upon enrollment, unless member is already under the care of their Primary Care Provider prior to enrollment.

Chronic disease management, including the use of the EDWP Enhanced Case Management Physician Letter twice a year

Communication with Case Managers as needed.

Reliance by Primary Care Provider on case management staff for information by way of the EDWP Enhanced Case Management Letter regarding:

- Care Plan variances
- Home environment
- Informal support
- Community services
-

Case management role includes assisting members in carrying out Primary Care Physician orders and interventions

Referral, coordination and authorization for specialists, hospitalizations, home health and Ancillary services.

Wellness promotion and preventive health measures, including immunizations, cancer screenings, vision and hearing screenings, etc.

803 Site Medical Director

The Site Medical Director occupies a unique position of influence in local perceptions of Community Based Long-Term Care. The Medical Director may also be a Nurse Practitioner, or a Physician Assistant working under the direction of a medical doctor. A copy of the supervising physician must be kept in office. The Medical Director will ideally have a strong history and connection with the local medical community, facilitating understanding of the model and fostering support for member and program goals. The Medical Director will participate actively on the site's multidisciplinary team and will advocate on behalf of the program or individual member with the local health system or other physicians.

Specific responsibilities of the Medical Director include working with the Multi-disciplinary team to:

a) Advise on the local site's policies/procedures
b) Advise on the local site's internal grievances
c) Advocate on behalf of the program or individual member with the local health system(s), and community physicians
d) Assist with development of and sign Care Plan on admission and annually.
e) Confirm the HCBS services ordered, frequency and duration as indicated by the MDS-HC assessment

tool, signing the SOURCE Level of Care and Placement Instrument form for new members, and reassessments, at least annually

f) Review PCP medical record notes at admission, reassessments and with any condition change. Sign Care Plan for any changes.
g) Review service delivery issues
h) Review repeated hospital encounters for individual members
i) Review issues of chronic non-compliance
j) Review discharges to nursing homes.
k) Review complex referrals

804 Case Management

Case Management is a collaborative process which includes assessing, implementing, coordinating, monitoring, evaluating options and services required to meet individual needs and making referrals as needed. SOURCE case managers may consist of nurses, RN and LPN, currently licensed in Georgia and social workers. Starting July 1, 2019, all new hires for case management will be RN or LPN licensed in Georgia, or a social worker with a bachelor's degree in social work or comparable field.

The four components of case management are described as follows:

- Assessment and periodic reassessment – determine service needs, including activities that focus on needs identification, to determine the need for any medical, educational, social, or other services. Assessments are comprehensive in nature and should address all needs of the individual, including an individual's strengths and preferences, and consider the individual's physical and social environment.

- Development and periodic revision of the Care Plan – specifies the goals and actions to address the medical, social, educational, and other services needed by the eligible individual, as collected through an assessment or reassessment.

- Referral and related activities – help an individual obtain needed services, including activities that help link eligible individuals with medical, social, educational providers, or other programs and services that are capable of providing needed services to address identified needs.

- Monitoring and follow-up activities – include activities and contacts that are necessary to ensure that the care plan is effectively implemented and adequately addresses the needs of the eligible individual. These activities should take place at least on a quarterly basis for face to face contacts and at least monthly for phone contacts. The monitoring and follow-up activity determine whether the services are being furnished in accordance with the individual's care plan; services are adequate to meet the needs of the individual; and there are changes in the needs or status of the individual.

Starting July 1, 2019, EDWP Case Management utilizes a standardized mechanism by which waiver case managers are certified to provide care coordination to members. All waiver case managers are required to become certified to establish baseline quality performance standards. Certification curriculum will include online module performance testing. Topics will include waiver eligibility and program options, quality management requirements, case management roles and responsibilities and person-centered planning. Existing case management will have 6 months to complete the required certification and new hires must complete training within 60 days from the hire date.

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

805 Case Management Supervision

EDWP Case Management utilizes a standardized mechanism by which waiver case managers are certified to provide care coordination to members. All waiver case managers are required to become certified to establish baseline quality performance standards. Certification curriculum will include online module performance testing. Topics will include waiver eligibility and program options, quality management requirements, case management roles and responsibilities and person-centered planning. Existing case management will have 6 months to complete the required certification and new hires must complete training within 60 days from the hire date.

Case Managers regularly face difficult situations requiring consultation with their supervisor and review of options to assist the member. The case management supervisor will ensure that Case Managers have the benefit of an additional perspective in decision making. The case management supervisor will meet with staff as needed when these types of issues arise.

Note: Case Management Supervisors are required to attend TTT quarterly.

806 SOURCE CASE MANAGEMENT TEAM

a) Each SOURCE Enhanced Case Management Team convenes a formal multidisciplinary team meeting at least weekly, to perform the following functions:

Review new admissions and confirm/verify the care plan and need for HCBS services, along with service type, frequency and duration
Complete/Review Discharge Planning for new, reassessed and discharged
Authorize service plans for ongoing members
Develop site-specific policies and procedures
Track and analyze repeated hospital encounters for individuals
Hear issues of non-compliance and involuntary discharge
Review chronic Care plan problems and potential nursing home discharges
Review provider or service delivery complications
Review discharges to nursing homes, prior to the date of discharge
Review utilization data
Review complex referrals

At a minimum, membership on the team will include: Medical Director, the Program Manager, Case Management Supervisory Staff, an RN/LPN and Case Manager presenting new members or information. As needed other clinical, case management or administrative staff members may participate in the team meeting. At the team meetings, the **member's initial assessment, annual re-assessments, and Modified Assessments will be reviewed. The Medical Director's signature on the EDWP Level of Care and Placement Instrument form will be required at the meeting. RN must sign on the next business day of the Medical Director's signature.**

807 Community Services Providers

All community services providers must first be enrolled under CCSP and must comply with CCSP policies and procedures unless indicated otherwise in this manual. As of July 1st, 2013, SOURCE opened enrollment to all current CCSP HCBS providers in good standing. Providers will need to enroll in SOURCE per directions found in

section 608. Compliance with increased performance expectations is expected for all SOURCE providers to achieve optimal health states for SOURCE members. SOURCE emphasizes the provider role in achieving outcomes associated with community residence and optimal health status for SOURCE members. This is accomplished by working closely with the Care Management agency and remaining compliant with current policy. When contacted by the SOURCE Case Management Agency and a client is brokered, the provider must abide by all SOURCE rules and conditions, including maintaining current on CCSP policy.

Reimbursed services through SOURCE are:

Personal Support Services/Extended Personal Support (PSS/EPS)
Consumer Directed Option PSS
Structured Family Caregiving (Required completion of the Appendix D)
Adult Day Health (ADH)
Home Delivered Meals (HDM)
Alternative Living Services (ALS)
Emergency Response System (ERS)
Home Delivered Services (HDS)
Skilled Nursing Services (SNS) (only used when all other home health agency options have been exhausted, ref. chapter 1900 of CCSP Manual)

Community services primarily offer assistance to members in activities of daily living (ADLs) and instrumental activities of daily living (IADLs). Self-care and informal sources are first maximized before accessing HCBS in SOURCE. The CCSP/SOURCE provider manuals may be referenced for definitions of these service categories. Unless otherwise noted in this document, Community service providers will operate in accordance with EDWP provider-specific manuals. Copies of EDWP provider-specific manuals are available through the Gainwell Technologies Website: www.mmis.georgia.gov

Key characteristics of the SOURCE provider role (and used for provider compliance):

a) Intensified communication/coordination with case management staff, over conventional HCBS programs

b) Commitment to continued service for members with challenging personal situations or diagnoses

c) Demonstrated efforts to serve manpower shortage areas

d) Service for members needing PSS/EPS hours both above traditional service levels and below

e) Willingness to flex service levels as authorized by Case Manager, in response to the complex or unpredictable status of individual members

f) Customer satisfaction standards exceeding basic licensing requirements; specific areas of accountability include:
   Reliability of service, including early morning or late evening visits
   Competency, compatibility, and consistency of staffing
   Responsiveness to member and staff concerns, including the scope of care as described by the member or caregiver
   Coordination with Case Manager

g) Regular measurement of performance

h) Complaint Log for providers will be maintained on those that clients have continuous issues with.

i) An active 24-hour on-call service that coordinates dependably with Case Manager and member's

Provider and Caregiver

901. SCREENING

Potential SOURCE members will be screened to determine likely eligibility using the Determination of Need – Revised (DON-R) screening tool. The tool was designed and validated for use in telephonic screening and provides a method for prioritizing SOURCE applicants for admission. SOURCE screening is performed by the SOURCE Enhanced Case Management agencies, usually at the time of applicant inquiry by telephone. Screening is conducted by phone or can be conducted face to face in the case of difficult to screen individuals (those with communication impairment, no telephone, or cognitive impairment). Referrals may come from many sources, including but not limited to:

a) Hospital discharge planners
b) Physician offices
c) Family members or other informal caregivers
d) Community social service agencies
e) Home health agencies or other health system organizations
f) HCBS Service Providers

Procedures:

a) Inquiries will be documented using the DON-R tool along with the SOURCE screening form used for collection of demographic data.

b) Medicaid Eligibility: Screening staff will access the GAMMIS website to confirm a potential member's eligibility status. For persons not eligible for SOURCE or not interested in joining the program, appropriate referrals to other services or organizations will be made (including referral to the Social Security Administration if the person screened may be eligible for SSI). See also Policy No. 1405, Right to Appeal.

c) Functional Eligibility: Full screening is completed within three business days of the initial inquiry. Extenuating circumstances which prevent meeting the standard of promptness will be documented on the Screening Form. All telephone screening is only considered complete when performed using the Determination of Need – Revised assessment tool.

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

d) Depending upon availability of SOURCE benefit funds, applicants who have been telephone screened and determined eligible for the Program may have to be placed on a waiting list for full assessment. When placed on a waiting list, an applicant will be advised of his right to be re-screened if his functional need or status changes. In the absence of applicant-initiated contact, applicants will be rescreened by the SOURCE EPCCM agency that conducted the first screening using telephone contact and re-administration of the DON-R every 120 days if held on the waiting list.

e) In the case of wait lists for SOURCE admission, the EPCCM Agency sends the completed DON-R with legible demographic information to the DCH Program Specialist via

email or use of thee-mail address via secure method of transmission.

f) For those meeting SOURCE Medicaid eligibility criteria and wishing to pursue enrollment, information gathered from the screening will be used to determine admission priority and returned to the submitting EPCCM Agency to schedule assessment as program slots are available. In the case of a waiting list, those with the highest level of need as identified through use of the DON-R are admitted to the SOURCE Program.

g) Members who do not meet the eligibility requirements at the screening will be sent a Notice of Denial of Level of Care Elderly and Disabled Waiver Program Eligibility letter will be mailed to the applicant. The applicant has 30 days in which to request an appeal. (See Notice of Denial of Level of Care Elderly and Disabled Waiver Program Eligibility letter in the EDWP Forms Manual.)5382 and Section 1404

902. INITIAL ASSESSMENT

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

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

All persons who meet screening requirements for SOURCE, and program slots are available will be formally assessed in their homes (exceptions noted below) by EDWP RN/LPN prior to initiation of services, using the MDS-HC (v9) and other SOURCE approved Assessment Tools. The purposes of assessments are:

a) Evaluation of the member's medical and health status; functional ability; social, emotional and environmental factors related to illness, and support system, formal and informal, Level of Care determination, Care Plan development and delivery of community services.

b) Identification of urgent problems which require prompt attention.

c) Evaluate the member's home environment (assessing the physical structure and home safety, meeting caregivers or family members as indicated to assess informal support system, etc.). See Section 1005, Self-Care and Informal Support.

Exceptions to member "in home" assessment

a) Member is receiving in-patient care in an acute care facility awaiting discharge to a community

environment

b) Member is currently residing in a nursing home

NOTE: For SOURCE Case Management agencies working in the electronic data system the following components of assessments will be done within the system and utilize electronic signatures if applicable:

MDS-HC v 9 LPN and RN sign MDS and the RN signature acts as the Appendix T when in Harmony.

EDWP Monthly/Quarterly Contact Sheet (both are incorporated into one form)

EDWP Quarterly Provider Contact Sheet

Modified Reassessment

Care Plans and Task Lists and Evaluations

Discharge Plan

Emergency Disaster Plan

Referral and Tracking

Advanced Assessments such as MMSE, SLUMS, PHQ9, Falls Risk

Evaluations for ADH, ALS, PSS, SNS, HDM, ERS

Service Order for providers

Medications will be put in the Medication TAB, do not add to MDS

Case notes in the Notes tab

Procedures for Initial Assessment:

a) The assessment process will be initiated within 5 business days of release from wait list. In situations where the standard of promptness is unmet, justification for failure to meet will be documented in the case notes of the member file.

b) Nurses will assess all potential members using the MDS-HC (v9) assessment tool and determine eligibility for the Program based on ILOC criteria and need for community-based services.

c) When the MDS-HC is completed by an LPN, within ten (10) business days from the date of the assessment, the RN reviews the MDS-HC, completes and signs the MDS-HC Participant form to indicate supervisory review.

d) MDS-HC Participant Form confirms all who are present and assisted in interview for the MDS-HC and that the MDS-HC received RN review and agreement. It must be signed within 10 business days of the MDS HC assessment by the RN. It is part of the member assessment. It will also be uploaded to AHS with the assessment packet. RN signature in the electronic MDS will serve as proof of RN review of the forms if using Harmony.

e) Applicants who meet ILOC but have all needs met by informal supporters are not appropriate for admission to SOURCE.

f) Assessments will take place in the home of the potential member, unless enrollment is necessary prior to discharge from a hospital, nursing home or rehabilitation facility.

g) A caregiver, family member or advocate shall be present whenever possible during assessments for members with a legally appointed guardian, a known diagnosis of Alzheimer's or Dementia, or other known significant cognitive or psychiatric conditions

N o t e : Individuals who are wards under legal guardianship procedures may not enroll themselves in the SOURCE Program nor sign program-related documents

h) While an informal caregiver may assist with answering assessment questions as needed (see above in particular), the potential new member is the primary source of information whenever possible and is interviewed in person.

i) The Case Manager or nurse will review the program's operations with the potential member following the assessment, including selection of the site as Preferred SOURCE agency.

j) The following forms will be reviewed with the SOURCE member and signed.

- Updated SOURCE Rights and Responsibilities, obtaining signatures on two copies (one left with the member, one for filing in the administrative chart) and including information on a member's right to appeal decisions of the site, signed at admission and at reassessment, at least annually.
- EDWP Authorization for Release Authorization and Informed Consent signed at admission, at reassessment, and at quarterly reviews.
- DCH Information about Elder Abuse, Neglect and/or Exploitation

Forms for review and signature may also include SFC Validation and Caregiver Attestation Form if needed, EDWP Info Sheet, Updated Case Management List, New EDWP Physician Evaluation, New Disease Management Physician Letter, Estate Recovery Information, Discharge Plan and Disaster Planning checklist at initial and reassessment, and EDWP Consent form.

k) The Case Manager will provide the member/caregiver with the names of all Primary Care Physicians in the area where member resides. Member may choose to use their current PCP if desired. All members enrolling must agree to use a Primary Care Physician.

l) The Case Manager must include directions to the member's home starting from the local SOURCE Enhanced Case Management office to member's home address.

m) Following completion of the admission assessment, the Case Manager will record all recommended services on the Care Plan Form.

n) Case Manager will request and record member feedback and signatures from both member

and CM

903. Program Admission Procedures

SOURCE admission occurs with these steps following assessment:

1. Initial determination of eligibility using the definition in section 801.3 as recommended by the assessment nurse using the information gathered from the MDS-HC (v9) and compared to the Level of Care Criteria
2. Submitting the assessment packet to Alliant Health Solutions (AHS), the Division of Medicaid's medical management vendor, for validation of level of care.
3. Prepare information on Community Supports available to member that may be used to support the member during their stay in SOURCE or information that can be used to support member at termination. Prepare for Discharge at the time of enrollment.
4. Receive confirmation of the level of care approval from AHS.
5. Review new/reassessed members by a multidisciplinary team.
6. Prepare Care Plan. Admission is considered complete upon the Medical Director's order/signature on the Level of Care and Placement Instrument which provides the physician order for HCBS services, confirms LOC, and RN signature for certification of level of care. Care Plan completion is required within fourteen (14) days of this date
7. Upon completion of enrollment (synonymous with the PA approval/effective date) and initiation

    A. Provide the following completed documents to all service providers, See 606.4 of General Services Manual and EDWP CCSP Manual 1837:

    - MDS-HC and MDS-HC Participant Form with RN signature and date
    - Medication List
    - SOURCE Level of Care and Placement Instrument; must contain required signatures (physician and RN) and date of signatures
    - Level of Care Criteria Justification
    - The EDWP Care Plan and task lists
    - SOURCE Service Order
    - Discharge Form
    - Emergency Disaster Plan
    - Nutritional Assessment for Home Delivered Meals
    - Any Advanced Assessments
    - Directions to the member's home, starting from the local SOURCE site to the member's home address Prior Authorization numbers (may put on transfer, Care plan, or App F

Rev. 07/22 Note: All services ordered must be listed on SOURCE Level of Care and Placement Instrument. The exception to this is if the member is not due for a reevaluation and the new service ordered does not require a reevaluation/ reassessment; in the case of new services ordered without full reassessment, the services are added on the Care Plan and indicated as ordered by physician or Medical Director on the Change in Service-No Reassessment letter.

B. Provide the following completed documents to the member at the first face to face visit:

- EDWP Program Participation Form 5389
- Signed copy of the Service Order

NOTE: Assessment packets are submitted only through the secure AHS web portal for review. All correspondence related to admissions will be conducted through the secure web portal.

C. Documents to be submitted to Alliant Health Services via web portal include:

Level of Care and Placement Form (filled out in entirety)

Demographics

Level of Care Criteria justification for Intermediate Nursing Facility Care

MDS-HC form and the MDS-HC Participant Form with RN signature

Advanced assessments, if done

Medication Record Form

Case Notes

DON-R Screening Tool for initial assessments only

Process for Routine admissions:

For HCBS provider billing, SOURCE members are enrolled in the program after Prior Authorization LOC approval is given by AHS. The Prior Authorization effective date is the same date of the Initial assessment. SOURCE physician signature authorizes approval of the HCBS services including enhanced case management. The R.N. signs the ILOC form after concurrence is provided by AHS or DCH review.

Process for members who meet eligibility:

Eligibility requires AHS approval for any initial SOURCE clients or SOURCE member reassessments on or after 9/30/2013. Services may not be delivered until the AHS approval and a valid SOURCE Level of Care and Placement Instrument ordering HCBS services is in place.

Initial Admission Overview:

The Case Management Agency makes an appointment with the member for a fac- to-face interview.
A nurse completes the MDS HC.
When the MDS-HC is completed by an LPN, within ten (10) business days from the date of the assessment, the RN reviews the MDS-HC, completes and signs the MDS-HC Participant form to indicate RN review.
The MDS-HC Participant form is a signature page that confirms all who assisted in the interview for the MDS-HC that the MDS-HC received RN review and agreement. It must be signed by the RN within 10 business days of the MDS HC assessment. It is part of the member assessment.
Upon completion of enrollment and initiation of services, case manager will provide the following completed documents to all community service providers, See 606.4 of General Services Manual:

- MDS-HC and MDS-HC signature page with RN signature and date
- Medication List
- SOURCE Level of Care and Placement Instrument; must contain required signatures (physician and RN) and date of signatures
- Level of Care Criteria Form
- The EDWP Care Plan, Service Order, and provider specific Task Lists
- Release of Information and Consent Form
- SOURCE Service Order
- Discharge Plan
- Disaster Plan
- Nutritional Assessment for Home Delivered Meals
- Any Advanced Assessments
- Directions to the member's home, starting from the local SOURCE site to the member's home address

All sites shall maintain in the front of each chart for each active member a current Face Sheet with basic demographic information, to include at least the following:

- Name
- Date of Birth
- Address/Phone
- Male/Female
- Medicare/Medicaid or SSN numbers
- Directions to member's home
- Responsible party information (phone, address) if applicable
- Emergency contact information (phone, address)
- SOURCE PCP
- SOURCE Case Manager
- Date of SOURCE enrollment
- Diagnosis
- Advance Directives- Yes/No
- Discharge date

Case managers will provide the following completed documents to the member at the next face to face visit:

- EDWP Program Participation Form 5389
- Signed copy of the Service Order

The Case Manager submits documentation via the web portal to AHS. Exceptions, if the member has a current Prior Authorization that is not expiring within 3 months, it is not necessary to submit to AHS. AHS reviews the assessment package and confirms Level of Care. Documents to be submitted via web portal include:

- Level of Care and Placement Form (filled out in entirety)
- Demographics
- Level of Care Criteria form for Intermediate Nursing Facility Care

- MDS-HC form and the with RN signature
- Advanced assessments, if done
- Medication Record Form
- Case Notes (6 months of Case notes for reassessment)

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

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

Alliant Health Solutions and/or DCH staff may request medical records to support any level of care determination.

Following level of care approval by AHS, the member assessment and care plan recommendations are to be reviewed by the multidisciplinary team.

Case Managers will use the following format in presenting newly eligible members to the weekly admissions meeting of the multidisciplinary team:

(1.) Member name, age and diagnoses
(2.) Caregiver information, if applicable
(3.) ADL/IADL impairments from MDS-HC Assessment
(4.) Current medications
(5.) SOURCE physician selected from panel
(6.) Factors complicating care planning (lack of support, recent hospitalization, etc.)
(7.) Recommended SOURCE services
(8.) Other community services planned or in place
(9.) ADH level recommended (See ADH manual)

The team reviews information to ensure that:

(1.) Informal support is analyzed and maximized
(2.) Services recommended are logical and cost effective
(3.) Key health status issues are identified, with urgent problems addressed

Following discussion of information presented, the multidisciplinary team reviews the Level of Care, MDS HC and other SOURCE approved assessment tools for development of the care plan and service plan.

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The Medical Director and/or member's primary care physician confirms that the member meets eligibility requirements for the SOURCE Program and orders specific services on the SOURCE Level of Care and Placement Instrument by signature.

Once the physician signature is on the level of care form, then a Service Prior Authorization can be created in the Medicaid information System.

If applicable, the team also assigns the ADH level of service.

AHS communicates the level of care approvals to DCH for admission upon request.

Ineligible members

Ineligible Initial Clients (New Clients)

Process for new clients who do not meet admission criteria due to incomplete information uploaded (technical denial)

- AHS does not validate/does not confirm Level of Care and eligibility
- Sends a contact us to Case Management provider regarding documents left out of upload
- Denial for an incomplete application will only be communicated if the SOURCE agency fails to submit the require documents to AHS for review with-in 30 days.
- Required documents that should be uploaded listed above.

Process for new clients who do not meet LOC

- The SOURCE agency notifies the member and makes sure any questions are answered
- The agency Medical Director and R.N. DO NOT sign the SOURCE Level of Care
- SOURCE Agency reviews the discharge plan with community supports, adding information as needed, giving it to member when complete (See Discharge Planning sheet) Provide the discharge plan to the appropriate parties, upon request, at a hearing conducted by an Administrative Law Judge (ALJ) from the Office of State Administrative Hearings (OSAH) on an adverse action decision made by the Case Management, Alliant, or utilization review (UR). For a member denied at initial assessment, provide contact information on the AAA/ADRC based on the region where the member resides for non-waiver services they may be available to them. https://www.georgiaadrc.com/site/363/contact_us.aspx

Process for established members who do not meet continued eligibility at reassessment

- If a member does meets Level of Care (and does not appeal) or is discharged for any other reason, the site will notify all service providers and end all lines on the service Prior Authorization.
- Except in cases where member meets immediate discharge criteria (i.e. threatening behavior),
- the agency should attempt to determine if the member is going to appeal and give the member 30 days before ending the service Prior Authorization.
- Service Prior Authorizations should be ended in 30 days by the Case Management agency if member has not appealed.
- The appropriate forms should be placed in the member's chart.

904 Routine Reassessments (Complete Reassessment Packets)

Source members are evaluated for continued eligibility at least annually, and more often as necessary as directed by AHS, or as directed by DCH. Re-evaluations are to be completed by a licensed nurse (currently licensed in the state of Georgia). Re-evaluations completed by an LPN must be reviewed and approved by a supervising RN.

Reevaluations are sent to AHS to obtain approval. The SOURCE case management agency confirms that the member continues to meet criteria for:

Eligibility using the definition in section 801.3 including Intermediate Level of Care for nursing home placement

Continued eligibility, appropriateness, and need for SOURCE services

Allows for adjustment of the Care Plan goals and service plan. Note: All services ordered for member at the time of reevaluation must be listed on SOURCE Level of Care and Placement Instrument, Line 23

Schedule face to face with member starting 90 days prior to the expiration date of the current LOC and review with member/member representative all documents to be reviewed and signed, to include the Rights and Responsibilities, Authorization Release Authorization and Informed Consent, update Discharge Plan and Emergency Disaster forms, New Disease Management Physicians Letter.

1. Complete MDS-HC (v9) Assessment

2. Complete SOURCE Level of Care Placement Instrument

3. Discuss with member continued eligibility or if indicated possible ineligibility

4. Initiate the development of a new Care Plan with the member/representative

5. Obtain AHS approval on all annual reassessments with MDS

6. Present member information and documentation at multi-disciplinary team meeting

7. Complete certification of LOC and continued participation in SOURCE

8. Provide copies of reassessment documents to community service providers before LOC certification end date. The following documents are maintained as part of the SOURCE member clinical record, See 606.4 of General Services Manual.

    - The MDS-HC and MDS-HC signature page, with RN signature and date
    - SOURCE Level of Care and Placement Instrument, with required signature (s) and date (s)
    - Level of Care Criteria Form
    - Release of Information and Consent Form
    - The SOURCE Care Plan and Task Lists
    - SOURCE Service Order
    - Disaster Form
    - Discharge Form
    - Any Advanced Assessments
    - Directions to the member's home, starting from the local SOURCE site to the member's home address.

9. If member is not approved for SOURCE during the Reevaluation/Reassessment process, and the member appeals, a copy of the AHS notice of appeal or the member's copy of DCH Legal Services Division acceptance of member's appeal, will extend the LOC currently in place.

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

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

Alliant Health Solutions and/or DCH staff may request medical records to support any level of care determination.

NOTE: If members no longer meet eligibility criteria for SOURCE participation refer to Section 1405 and 1406 of this manual.

905 Modified Reevaluation/ Readmission into SOURCE

Modified Reevaluation Process may be used for members with Current PA greater than 3 months from expiration. Such as:

Client is discharged from a nursing home stay

- Client is discharged from an acute care hospital after a 60 day stay
- Significant change in client condition/situation
    - Significant change in mobility (from walking to unable to walk or w/c to bedbound)
    - Significant change in cognition (orientation, ability to make own decisions, make needs known)
    - Significant change in point of service (ALS to private home or vice versa)
    - Significant change in ability to participate in care needs (focus on decline in late loss ADLs from last MDS assessment)
- Adding a skilled service
- Terminating a skilled service
- Adding non-skilled service
- Received as a transfer from another agency or internal transfer
- Client is moving from PSS to determine a recent decline of the member that does not receive a daily 5 hour assessed need if requesting Structured Family Caregiving. A physician order will be added using the Change in Service Physician Letter signed by the PCP or Medical Director. CC completes the Appendix D to determine the 5 hours of care every day prior to ordering Structured Family Caregiving.

This policy is for Medicaid members who have an active Level of Care PA with Alliant. Interview of member for this process may be conducted by LPN or RN.

Procedure:

The LPN/RN completes the Modified Reassessment form with the Member/Representative.

Review and update Care Plan, Task Lists, and Service Order to include any changes noted in care needs.

If this is due to a transfer, be sure the Transfer Form is complete from the agency that transferred to receiving agency and it has been sent to AHS for LOC PA transfer.

RN reviews and signs modified reassessment form for members with active prior authorization/approval. RN supervisory review indicates that medications and treatments are consistent with diagnosis and appropriate to be given at home. All urgent Information is directly communicated to Case Management staff and documented.

COMMUNITY SERVICE PROVIDERS

Each Community Service Provider should receive this information following:

Source Modified Reassessment Sheet

Source Updated Care Plan, Service Order, and Task Lists

Authorization of Information and Informed Consent Form

Medication List if changes

If this is a new transfer in, include the MDS-HC and SOURCE Level of Care and Placement Instrument sent by the sending agency.

906. SOURCE Member

(Internal and External):

SOURCE members may transfer to another SOURCE site within the same company (Internal transfer) or to another SOURCE agency, CCSP agency, or ICWP agency (External transfer) and remain eligible for the Elderly and Disabled Waiver.

Upon notification of a transfer to your agency or leaving your agency, contact the member or member representative to verify informed choice of the transfer and date of transfer. Contact must be made with the receiving agency lead to determine that they will accept the member being transferred.

Discharging/Transferring Agency:

1. With a current LOC PA, Complete the Universal Waiver Transfer Form, to include the last date of service, and upload to Contact Us on MMIS LOC PA to request the transfer of LOC PA.
2. Notify the AAA for the CCSP agency with demographic information to create a chart in Harmony if applicable.
3. Send to receiving agency three months of documentation to include the most current MDS, Case Notes, Medication List, and SOURCE Level of Care and Placement Instrument. DO NOT obtain the Medical Director's signature on the SOURCE Level of Care and Placement Instrument to discharge waivered services when a member is transferred with a current LOC PA. Current SOURCE Level of Care and Placement Instrument is used to broker services with the receiving agency and is good until the LOC expires.
4. Notify HCBS providers of the last day of service for the discharging/transferring agency.
5. Ensure all lines on the service PA have ended.
6. The Transfer Form – Supplement Checklist must be completed in full to include providers name on the form and submit both transfer forms to the DCH Waiver Unit.

Receiving Agency:

1. LPN/RN will complete a home visit contact and complete the Modified Evaluation, discuss services, and review and revise the Care Plan if needed.

2. If the LOC is expiring within the next 60 days, the nurse will do the entire MDS and packet and submit to AHS for approval. Contact DCH to request it be expedited through AHS.

Transfers from SOURCE to CCSP no longer require care to begin on day one of the next month. Transfers can now occur on days other than the end of the month. The discharge date from one to the other must be agreed upon in advance so the worker can end date the services PA before the new services can begin. The two service PAs cannot overlap. The area the member is leaving (Discharging/Transferring Agency) will bill for the month the

transfer occurs. The Receiving Agency will bill the following month and ongoing after the transfer took place. Note: Transfers to ICWP are recommended on the first date of the month with communication between case management agencies occurring in the month prior to the transfer.

With the loss of the SSI category or any payment category of Medicaid payable for Source, the current case management has 3 days to notify the member, verify the reason for the loss of applicable category, and refer to case management in CCSP (can be same agency as Source if approved for CCSP and that county of residence) if unable to restore. DCH has the 449 clients automatically changed to CCSP Medicaid so the receiving CC site will upload the signed LOC and CCC to DFCS ASAP. The Source site will alert the applicable AAA in those 3 days and collaborate member choice of new agency. In the event the member refuses to transfer to CCSP, the Source Case Management will complete the termination from EDWP, with the issue of the 5382, and close the file out by the end of the current month if no appeal request.

IF	THEN
If client has been without services for greater than 60 days and has an active LOC PA of greater than 90 days prior to expiration	Have the nurse do a modified reassessment and update the care plan and send to the providers
If client has been without services for greater than 60 days and has an active LOC PA that is within the 90 days of the expiration	Have the nurse do a reassessment and upload to Alliant as a reassessment and new care plan and send to providers.
If client has been without services for greater than 60 days and the LOC expired during that time, if within 60 days of expiration	Have the nurse do a reassessment and upload to Alliant as a reassessment and dates will be adjusted to meet old LOC. Do a new care plan and send to providers.
If client has been without services for greater than 60 days and the LOC expired during that time and the expiration is greater than 60 days	Have nurse do an Initial assessment and upload to Alliant for a new LOC PA. Do a new care plan and send all new paperwork to providers.

1001. Care Plan

SOURCE utilizes Care Plans to develop an individualized plan of care to identify goals to achieve expected outcomes. Care Plan, designed around indicators associated with chronic illness and impairment, are individualized plans written and implemented for each member. Care plans, while not disease-specific, address risk factors held in common by people at the SOURCE Nursing Home Level of Care. The SOURCE Assessment nurse, with input from the case manager, is responsible for development of the member care plan at initial assessment and at each re-evaluation.

Members and informal caregivers, Primary Care Provider staff, RN's/LPN's and Case Managers, together implement the Care Plan, adjusting the plan when necessary to meet goals.

The program uses Care plans to:

a) Individualized case management practices
b) Identify roles for specific participants
c) Identify gaps in self-care/informal support, creating a framework for paid SOURCE services
d) Target and analyze problem areas for individual members and across the entire program

SOURCE promotes member independence, self-care and assistance from informal care givers. When appropriate, the case manager may coordinate education or training for members or informal care givers to teach direct care, patient education, and monitoring of chronic conditions. Self-Care and informal support are reflected in the development and implementation of each care plan. At minimum, the member Care plan will address the following:

- Nutrition/weight
- Skin care
- Key clinical indicators (blood pressure, blood sugar, weight monitoring and lab studies)
- Medication compliance
- Keeping appointments with primary care physicians
- Performance of ADLs and IADLs
- Transfers and mobility
- Problem behavior (s), if applicable
- Informal care giver support
- Discharge Planning
- Emergency Disaster Plan

1002 Care Plan Development and Completion

Care Plan development requires that the CM/LPN/RN use information gathered from many sources to produce and maintain a consensus between members/caregivers and Primary Care Providers to meet individual goals. The Source assessment nurse and case manager will evaluate the member's need for assistance with performance of his/her activities of daily living and instrumental activities of daily living, monitoring of chronic medical conditions and other areas which impact the member's ability to continue living in the community. Evaluation begins with the referral and screening process through the initial assessment and continues for the duration of the member's length of stay in the program. Assessment nurses and case managers will:

- Determine member formal and informal support, availability and reliability (Whenever possible, nurses/CM's will meet with informal caregivers to discuss care planning)
- Add to SOURCE Care Plan profiles when information is obtained from the member/family during the assessment

- Effective date and expiration date of the Care Plan will be taken from the Prior Authorization dates given by AHS.
- A new effective date that services were restarted may be documented by a Case Management agency on the care plan if service is interrupted during an active Prior Authorization.
- Short term hospitalizations (less than 2 weeks), or temporary moves will require a case note. Transfers and if the member has needs for different services will require the Change In Service Physician form signed by the PCP or Medical Director to be documented with a Care Plan, SOURCE Service Order, task lists and evaluations must be updated and case note written.
- A prolonged Span for hospitalization, nursing home stay, rehab stay, may meet requirements for a modified reevaluation and care plan, service order and task lists will be reviewed and changed if needed.
- Prior Authorization expiration dates are only given by AHS.
- Complete the Care Plan within fourteen (14) days of the completion of the enrollment process which includes determination of level of care, physician signature, and is finalized by the RN signature. Present the Care Plan at the Inter-Disciplinary Team. Medical Directors signature on the Level of Care form will confirm care plan approval.
- Case management or Physician may add or delete services (with explanation) for the member on the care plan. The Change In Services Physician letter signed by the Medical Director will confirm the changes.

NOTE: When a new service is required as the result of a change in member support or functional capacity; the Medical Director signature and date on the Change In Service Physician Letter will confirm his or her review and approval of the new plan of care.

1003 Completed Care Plan

Completed SOURCE Care plan will have understanding and agreement from the member/care giver and the Medical Director. The Case Manager will formally review the care plan goals every monthly and quarterly client contact.

Initial review of the care plan and task lists with the member confirms that:

- member understands expected outcomes
- plan accurately describes self-care capacity and informal resources
- reimbursed services are offered at the appropriate level
- Information on community services that will enhance member's wellbeing are provided.

Case managers will review care plan goals and task lists, evaluations during regularly scheduled quarterly contacts with the member to ensure that the plan is current and continues to support the member's ability to remain in the community. The provider task evaluation forms will be used to document any issues noted.

During the initial review of the individualized member care plan and task lists with the Medical Director, the following exchange of information will occur:

- PCP role in patient education and treatment from obtained medical records
- monitoring of chronic conditions at home

- self-care capacity/informal supports identified
- reimbursed services ordered

CM documents in case notes medical director's recommendations. Bi-annual PCP notification using the EDWP DM Physician Letter will include review of variances of the care plan goals.

Service provider review of Care plan allows provider agencies to:

- confirm the authorized services ordered
- understand and acknowledge service provider role in supporting member care plan goals
- understand the member and caregiver role (s) in meeting care plan goals

Care plans are discussed with provider on new enrollment/reassessments and with changes during provider meetings to ensure provider awareness of their role. EDWP Notification Form, referral, or other documented communication will be amended by the case notes as indicated to reflect changes in the care plan

1100 Reimbursed Services

To implement the Care Plan, the Case Manager will refer the new member for reimbursed services, if applicable. Information provided to the agency must be sufficient to allow for effective service delivery and accurate billing.

Procedures:

a) The member will choose their providers from active provider list.

b) Due to the complexity of care involved, Case Managers will discuss new referrals by phone or in person, for the following service categories:

(1) Personal support/extended personal support
(2) Adult Day Health
(3) Alternative Living Services
(4) Home Delivered Services
(5) Structured Family Caregivers
(6) Consumer Directed Personal Support

d) Home delivered meals and emergency response system referrals will not require a phone call prior to making the referral in writing.

e) The Case Manager will complete the SOURCE Service Order.

f) In addition to demographic information, the SOURCE Service Order must include specific units of service requested and the Authorization Number.

g) Additional information pertinent to service delivery for an individual member will be noted on the Service Order.

h) All providers will also receive copies of the following which are maintained as part of the SOURCE member clinical record:

- The MDS-HC and RN Review and Signature page.
- Medication List
- SOURCE Level of Care and Placement Instrument
- Level of Care Criteria
- The SOURCE Care Plan and task lists
- Rights and Responsibilities
- Discharge Summary
- Emergency Disaster form
- Demographics sheet

i) Providers will send the Case Manager an EDWP Notification Form confirming the service level and the date services will begin.

j) If the EDWP Notification Form does not match the Service Order, the Case Manager will call the provider to clarify the referral.

k) Changes in paid assistance will be documented in the Case Manager's notes and on the Care plan, See also Section 1405, Right to Appeal (regarding decreasing or terminating services)

(1) The Case Manager will review the recommended service change(s) with his/her supervisor.
(2) If the Supervisor approves the change, the Case Manager will authorize the new service level in writing, by completing the EDWP Notification Form and sending a copy of updated care plan and task lists to applicable service providers.
(3) The original EDWP Notification Form is filed in the member's chart.
(4) The Case Manager will amend the Care plan and task lists as indicated, forwarding an updated copy to the member/caregiver.

NOTE: EDWP Notification Forms are acknowledged, in writing by the receiving agency and returned to the initiating agency within three (3) business days.

l) Changes in paid assistance will be documented in the Case Manager's notes and on the Care Plan, by drawing a single line through the earlier Care Plan entry and initialing and dating the current entry. See also Section 1405, Right to Appeal (regarding decreasing or terminating services)

1200. Care plan Variances

A Care Plan Variance describes a goal not met by a member at any point during a quarterly review period. For any goal not met, corrective action by the Case Manager is required. The Case Manager will act quickly to help members resolve variances, to prevent further complications that may jeopardize health or functional status.

Procedures

a) Case Manager will identify the variance, recognizing problematic issues as goals not met and uncovering the source(s) of the problem.

b) Case Manager will act to resolve the variance. Specific steps taken will depend on the member's individual circumstances, and on which goal was not met and why. Examples of corrective action may include:

- Arranging patient education for the member or informal caregiver
- Scheduling an appointment with Primary Care Provider
- Increasing service levels or changing service categories
- Coordinating with provider on service delivery issues

c) The Case Manager will document all variances appropriately:

(1) If the variance was discovered or noted before the quarterly home visit, the Case Manager will indicate the issue on the Monthly Contact Sheet, the care plan, task lists, evaluation lists, and case notes as applicable.

(2) If the variance was discovered or noted at the quarterly review home visit, indicate the variance on the Contact Sheet Quarterly Review section, the care plan, task lists, evaluation lists and in the case notes.

(3) The Case Manager will further document corrective actions in the member's case on EDWP Notification Form to providers approving service level changes, on the Care Plan if a change to the plan was made, etc., as applicable.

(4) The Case Manager will document variances with the PCP on the bi-annual EDWP DM Physician Letter and service providers using the EDWP SOURCE Case Conference and Complaint Resolution as applicable

1300. Concurrent Review

Communication is key to the SOURCE concept of integration. Defined formally in the program as concurrent review, there are four fundamental principles to SOURCE communication:

- Preventive efforts will be effective and current
- Problems will be quickly identified
- Action will be promptly taken by the appropriate parties to resolve problems
- Resources will be appropriately targeted for maximum results and cost efficiency

Case Managers and Care plans are at the core of concurrent review in SOURCE. To reach the program's stated goals, Case Managers initiate and facilitate communication with SOURCE members/caregivers, Primary Care Providers, program supervisors, and if applicable, providers; Care Plans provide guidance and formal structure for the concurrent review process.

All key players in SOURCE may possess information on the member's current condition and on Care Plan variances; however, with increased contact, familiarity or specific skills, each contributes unique perspectives as well:

Members/CG:	current condition (self-report); preferences; capabilities dynamics/ informal support
Primary Care	clinical condition, recommended treatments and compliance**;** information from diagnostic procedures, specialist visits, etc.
Providers:	current condition as observed by trained staff; household dynamics/informal support as observed externally

In addition to the program's key players, concurrent review includes other entities as appropriate, on an individual basis (example: dialysis center patients) or for a limited time (example: hospitalizations).

The job of the Case Manager and his or her supervisor is to analyze and use all information received to help the SOURCE member stay as healthy as possible and to meet Care Plan goals.

Communication with key players falls into two categories: scheduled or PRN (as needed in response to recognized triggers). Scheduled contacts serve as an overview for key players, an opportunity to spot patterns or trends and respond preventively. PRN contacts more typically address individual issues as they arise.

1301. <u>Scheduled Contacts with Members</u>

The Case Manager will regularly initiate contact with the members/caregivers and will make follow up contacts as needed with providers, Primary Care Providers, etc., on a member's behalf.

The Case Manager will also respond to calls initiated by SOURCE members/caregivers or on behalf of members, again taking follow-up steps as necessary. While minimum standards for contact are described below, the Case Manager will communicate with or on behalf of members as often as necessary to meet Care Plan goals and to stabilize or improve health status.

Direct contact between members/caregiver and providers also occurs frequently in the model; the Case Manager encourages engagement of the members/caregivers to the fullest extent possible in working toward optimal health and functional status.

Scheduled contacts with members/caregiver will occur according to the following timetable, at a minimum. The Quarterly Contact Sheet and the Care Plan, task lists, and evaluations will be used to record scheduled member contacts, appended by member case notes as necessary.

Monthly case notes must reflect what type of contact the Case Manager had with the member and a summary of what was discussed. Quarterly case notes must reflect review of member's Care Plan, which will include goals not met, and a plan of improvement/correction. Case notes must reflect follow up to assure the plan is working, and resolution of identified problems.

1302. <u>Procedures for Scheduled Contacts</u>:

a) **SOURCE Service Confirmation:** The Case Manager will confirm initiation of services during monthly contact following referral. The CM will take any follow-up steps required if services have not begun. Service referrals and confirmation will be indicated in case notes, on a EDWP Notification Form (ENF) or on a SOURCE Referral Form.

b) **Monthly Contacts:** The Case Manager will contact all members a minimum of once each month, to be documented on the Contact Sheet and in case notes if necessary.

(1) The Case Manager will indicate the method of contact (phone, home visit, other).
(2) The Case Manager will review goals of the Care Plan with the member/caregiver and will ask the member/caregiver to report any additional health or functional status issues, including initial PCP visit as applicable.
(3) For Care Plan outcomes with multiple goals, the Case Manager will indicate which goal was not met.
(4) The Case Manager will take appropriate follow-up actions as indicated.
(5) The Case Manager will sign and date the Contact Sheet for each monthly contact.
(6) Monthly contacts will be documented by the Case Manager on the contact sheet, appended by case note entries if required for complete documentation of service quality, progress toward goals and any other issues impacting care.

c) **Quarterly Reviews:** The Case Manager will formally review Care Plan goals every quarter.

(1) At the member's home, the Case Manager will review goals of the Care Plan with the member/caregiver.
(2) The Case Manager will review the existing Care Plan, and Task Lists, making updates as indicated due to changes in health/functional status of the member, informal support changes, etc.
(3) For a goal not met, the Case Manager will discuss with the member/caregiver options on how best to resolve variance.
(4) The Case Manager will ask the member/caregiver to report any other issues potentially jeopardizing health or functional status.

(5) The Case Manager will observe the member's household for cleanliness and safety.

(6) Quarterly contacts will be documented by the Case Manager on the contact sheet, appended by case notes if necessary.

(7) The Case Manager will take any additional follow-up actions indicated by the quarterly review.

(8) Changes to the Care Plan will be documented dated and signed by the Case Manager on the Care Plan.

(9) Copies of the new Care Plan, Service Order, Evaluations and Authorization of Information and Informed Consent form will be provided to the service providers.

d) **Re-evaluations:** A formal re-evaluation will be completed for all members annually. These will be submitted to AHS following instructions in section 904:

(1) RN/LPN will complete the MDS-HC (V9) level of care assessment and medication list. A new Records Release Authorization and Member Rights and Responsibilities must be signed and dated.

(2) The Case Manager will review the existing Care Plan, services and any issues jeopardizing the health or functional status of the member at the re-evaluation, following the procedures for quarterly reviews.

(3) A new Care Plan will be developed and reviewed for each member, following procedures from

(4) The level of care will be reviewed at weekly teams meeting and Medical Directors signature on the new Level of Care form will justify the new service order, care plan, and task lists.

(5) AHS or DCH will validate Level of Care with the complete assessment package submitted by the Case Management Agency as of 9/30/2013.

(6) Recommended changes in the Level of Care will be reviewed by the site's multidisciplinary team as determined by the MDS-HC assessment as conducted by the RN/LPN.

(7) The R.N. and Medical director signature on the Level of Care and Placement form should follow (as of 9.30.2013 after AHS validation) with multidisciplinary team review and confirmation

Note: a SOURCE Level of Care and Placement Instrument must be completed, at least annually, to verify continued Level of Care eligibility unless a legal notice is given to extend the expiration date

It is strongly recommended that at the Case Management third quarter face to face visit, the Member is assisted to make a functional assessment appoint with their PCP. The functional assessment document should be given with explanation to the PCP for this visit and upon completion, submitted to AHS. See EDWP Physician Evaluation form.

1303. Scheduled Contacts with Primary Care Provider

Primary Care Providers will be kept abreast of the member's care and concerns via the ECM DM Physician Letter that is submitted initially and bi-annually to the physician. The letter's intent is to provide information on the status of the member, inform of applicable problems quickly and share information on resources (informal and paid) effectively. Changes/updates are discussed and any PCP recommendations from return of this letter are to be documented in the case notes. Special attention should be given to any problems, variances, and all Incident Reports that the member may have had since the last letter for to PCP in the disease management process.

1304. PROCEDURES

For all SOURCE members communication between the Case Manager and the primary care provider will take place following the approval of the Initial assessment and at least bi-annually thereafter using the EDWP Physician Letter.

Observations in health or functional status
Incident Reports if not already reported to physician
Care Plan variances
Observations noted in the home.
Request for Equipment/supply needs
Medication List
Clinical Problems to include Hospitalizations

For new members: Attach Care Plan

This form is not intended for return by the Physician but may do so if needed and updated information must be put in the case notes and changes made to Care Plan if needed.

1305 Contacts with Service Providers

In addition to the four principle themes of concurrent review described earlier, contacts ensure that the SOURCE Enhanced Case Management and providers share the same understanding of services levels and responsibilities.

1306. <u>Procedures for Scheduled/PRN Contacts with Direct Service Providers</u>

Member initial referrals, discrepancies, discharges:

SOURCE Case Managers will document exchange of information with Direct Service Providers bi-annually and PRN utilizing the EDWP Provider Case Conference and Complaint Resolution form when reviewing service delivery/provider performance issues, dissatisfaction, and other areas requiring resolution. Follow up should occur after reports are received by phone, face to face, or written communication.

- Details of complaints/concerns requiring resolution will include:
  - Re-brokering of Provider – before re-brokering ALS, ADH, PSS/EPS, or SFC services.
  - Service Order Issues – member complaints
  - Provider/Case Management Complaint – failure to provide timely documentation
  - Client/Caregiver/Family Complaint – behaviors, requests to change Case Manager/aid assignment, other
  - When applicable, DCH Incident Reports (initial and follow up) may include the EDWP Provider Case Conference and Complaint Resolution form.
  - Case Management will document action needed, responsible party, and final complaint resolution in case notes.

- SOURCE Case Managers and Direct Service Providers will utilize the EDWP Notification Form to communicate. EDWP Notification Form will be received from providers prior to adjustments on the Service PA.

- A complaint log will be maintained by Case Management on those providers with frequent complaints such as the member not receiving timely services or poor services in the home.

- Bi-annual conferences will take place with providers serving a site's members, unless otherwise specified on the SOURCE Case Management Complaint Log, for these services:

  - Adult Day Health
  - Personal Support/Extended Personal Support
  - Alternative Living Services

NOTE: With the agreement of both the SOURCE Site (EPCCM) and the provider, conferences may

take place by phone, or by a mutually agreed upon electronic method. Provider conferences will include for Enhanced Case Management members served by the agency, efforts to resolve:

- Member Care Plan variances and Incident Reports
- Potential nursing home placement
- Member service issues and service delivery complications

Following completion of the annual re-evaluation for each SOURCE member, the case manager will send to each provider the updated Care Plan. Changes in service units or schedules or significant changes in responsible parties will be accompanied by an EDWP Notification Form to provider affected.

For discharges initiated by the SOURCE Enhanced Case Management, the provider will confirm notice of a service discharge by sending a completed EDWP Notification Form to the Case Manager.

For discharge of a member initiated by the provider, the provider will notify the site of a discharge using the EDWP Notification Form. Discharge by a provider should ONLY occur after a case conference is held with the case manager, member, and service provider. A thirty-day (30) discharge letter must be issued.

1307. Contacts with Case Management Supervisor

Contacts with the Case Manager Supervisor assists the Case Manager in negotiating complex situations among multiple parties. Case Management supervision will occur on an as needed basis.

1309. PRN Contacts

Problems complicating the lives of people with chronic illness may not coincide with scheduled monthly or quarterly Case Manager contacts. The SOURCE model places responsibility on Case Managers to ensure that communication with or between the right players happens at the right time to meet program and Care Plan goals.

Communications with members (and subsequent follow-up actions) that fall between scheduled contacts are made in response to member need. While most such contacts fall into areas related to clinical/functional status or service delivery, members may also contact Case Managers about eligibility, housing, items not covered by third party payers, etc. – in short, any issue potentially jeopardizing their ability to continue living in the community.

Providers (particularly PSS/EPS, ADH and ALS) frequently develop a close relationship with members/CG for several reasons:

- The frequency with which they encounter members/CGs
- The intensely personal nature of community services
- The social isolation of some members

Communication with the Case Manager Supervisor around identified triggers is also critical, allowing the Case Manager to share the substantial responsibility of making decisions and taking actions that best support members in community living.

Procedures:

1. All key players in the program will be encouraged to report to Case Manager's any issues that threaten a member's health status or ability to live in the community.

2. All key players will be educated on using the SOURCE 24-hour phone number for case management and primary care assistance offered from the site.

3. All key players will identify a key contact person to facilitate and communication for SOURCE members (may be the actual member, as indicated).

4. The individual SOURCE CM assigned to a member is the contact person identified for key players.

5. Triggers for PRN communication between players are:
    - Care Plan variances
    - Potential nursing home placement
    - Hospital encounters—inpatient or emergency department
    - Acute illness/exacerbation of chronic condition
    - Significant change in function—physical or cognitive
    - Suspected abuse or neglect
    - Service delivery complications
    - Housing/other residential issues
    - Family dynamics/informal support changes
    - Transportation needs
    - Member's desire to appeal a Case Manager decision Other factors jeopardizing health/functional status or community residence

Additional PRN communication with PCPs includes:

- New patients with SOURCE (review Care Plan; file copy on chart) Episodic/acute illness or exacerbation of chronic illness
- Medical triage/advice
- Referral to/communication with specialists (or ancillary services, diagnostic, etc.)
- Scheduling appointments
- Urgent equipment/supply needs
- Pharmacy/prescription needs.

6. If a specific CM is unavailable, the key player can relate information to the CM on call or to a CM supervisor.

7. Triggered information will flow from the CM to key players as indicated to resolve problems and achieve Care Plan goals.

8. Case Manager's will document PRN contacts and follow-up actions in a member's case notes, on Contact Sheets or on Care Plans as indicated.

9. Case Manager's will take any follow-up actions indicated to resolve outstanding issues, facilitate services or prevent further complications. Examples of follow-up actions includes:

- Changing Services, increases or decreases
- Evaluating functional changes by a home/hospital visit
- Scheduling a medical appointment
- Arranging a family conference to resolve care giving responsibilities
- Making transportation arrangements
- Referral for DME
- Assisting member in obtaining non-covered supplies
- Changes in Level of Care as determined by MDS-HC

1310. Disease State Management

In lieu of disease management provision by the Enhanced Case Management agency, case managers are able to use the EDWP Disease Management Physician Letter to provide information regarding the SOURCE member to the primary care physician or primary specialist medical provider. Note: If sending communication to a specialist provider, case managers will copy the primary care physician on the correspondence. The intent of the EDWP Disease Management Physician Letter is to provide information regarding the following:

- SOURCE services and potential impact on medical or health status
- Any change in condition or reported new symptoms
- A full list of all medications observed in the home with the frequency, dosage and prescribing physician. This would include any observations or concerns including member's failure to take the medication as prescribed.

The physician may or may not return the EDWP Disease Management Physician Letter but a copy of the tool must be retained in the chart along with the date and the method used to notify the physician, e.g. facsimile with confirmation, secure e-mail with confirmation of receipt, or U.S. Postal mail. All subsequent communication with the physician or other medical provider must be documented in the member record.

1400: Provider Performance Monitoring

To function effectively and assist members in meeting program goals, all key players in SOURCE must provide accessible, effective and reliable service. Enhanced Primary Care Case Management providers will comply with all monitoring and reporting activities as required by the Department of Community Health/Division of Medical Assistance.

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

Procedures:

***SOURCE CASE MANAGEMENT* SITES**

DCH LONG TERM CARE UNIT MAY REQUIRE A CORRECTIVE ACTION PLAN (CAP) FOR NON-COMPLIANCE IN THE FOLLOWING AREAS. PLEASE SEE THE REFERENCED SECTIONS FOR COMPLIANCE REQUIREMENTS:

- Source Programmatic Report (Monthly)
- SOURCE Case Management Team Meetings Documentation (See section 806)
- Program admission procedures: submitting all documentation to AHS (See section 903)
- Program admission procedures: documents submitted to providers (See section 903)
- Member Forms in Chart; forms present and documentation complete (See section 1300)
- Bi-annual Contacts with Primary Care Providers (See section 1305)
- Maintaining 24-hour call system: documentation and maintaining system (See section 1402)
- Hospital tracking through Incident Reporting and intervention Logs (See section 1403)
- Utilization Management oversight documentation (See section 1401)
- Standards of Promptness-Including submissions to AHS are prior to level of care expirations (timely)
- Discharge planning documents: Complete and Comprehensive discharge planning documentation.
- Guardian notification occurs as outlined (See 902 Procedures (d) and 1406 Right to Appeal)

DCH may require a Corrective Action Plan (CAP) for non-compliance. Sites must submit a CAP within 14 calendar days of notice of non-compliance and Corrective Action Plan. If an approved CAP is not properly applied or executed, DCH may impose additional sanctions ranging from new member suspensions up to suspension of participation as a Case Management Agency. The areas listed above are frequently requested areas, SOURCE Case Management Companies are still required to follow all SOURCE policy.

1401. Utilization Management

As stewards of significant state funding via the authorization of HCBS services, SOURCE Case Management Provider must ensure that the value of Medicaid's long- term care dollars is maximized. Sites will develop an internal system of monitoring and managing utilization of authorized home and community-based services. Conflict free Case Management assists to restrict conflict of interest by separating Case Management from Direct service providers.

Procedures:

1. Case managers will capitalize on self-care capability and informal support whenever feasible, and family care will be supplemented rather than replaced. Case managers will facilitate informal support with training and equipment as necessary.

2. At the site's admission committee, the case management team (including the medical director) will review recommendations to ensure the appropriateness of each service category; generally, least restrictive setting or service to achieve goals is preferred by members and is often less costly.

3. Sites will work to maintain function and overall health by addressing areas that may lead to increased impairment and higher HCBS costs – effective medical care, adequate housing, Care Plan goals (nutrition, medication adherence, etc.).

4. Case managers will use creativity in developing Care Plans, employing community resources other than Medicaid-reimbursed services that will contribute to meeting Care Plan goals.

5. Sites will maintain case manager awareness of the relationship between age and/or progressive illnesses and the increased need for paid services; case managers will develop initial Care Plan that are sufficient to meet goals but do not have extra capacity, to ensure that members may receive additional services if their level of impairment or informal support changes.

6. Sites will benchmark service plan costs by level, according to site averages or using information provided by the Department of Community Health for all SOURCE Case Management Provider.

7. Upon admission, sites will calculate service plan costs for comparison to the benchmarked standards.

8. Outliers will be reviewed further by the medical director, site manager and case management supervisor. Adjustments to service plans will be made when appropriate; balancing costs of care with achieving program and Care Plans goals.

9. Sites will develop an internal method for the ongoing identification of outliers that exceed benchmarked standards established by the site or by DCH. Triggers may be service costs, units of service, etc.

10. Services costs between up to $5000.00 should be evaluated locally by the Case Management Agency. Cost estimates exceeding the DCH established $5000.00 per month threshold must be approved by DCH Case Management specialists prior to the Care Plan implementation.

11. Upon completion of enrollment and initiation of services, case manager will provide the following documents to all community service providers:

- The MDS-HC with Medication List, and the MDS-HC Participant Form
- SOURCE Level of Care and Placement Instrument (must contain required signatures and date of signature)
- Level of Care Criteria Form
- The SOURCE Care Plan, Service Order, and Care Plan task lists
- Rights and Responsibilities
- Advance Directives if available to Case Management
- Directions to the member's home, starting from the local Source site Office to the member's home address
- Consent for Enrollment for initial and annual enrollment
- SOURCE EDWP Notification Form (ENF) (only when member has notable changes)

1402. 24-Hour On-Call

Management Provider will maintain a 24-hour a day/seven days per week/365 days per year on-call system that will:

- Optimize primary medical care for members by offering prompt attention to clinical complications or illness
- Assist members and informal caregivers in addressing after-hours service delivery issues promptly
- Help members avoid unnecessary emergency room visits by medical triage and advice

All sites will maintain a 24-hour phone line answered by a live voice.

a) At assessment, the case manager will leave for the member written information on how to contact the SOURCE Enhanced Case Management, including the 24-hour phone number.

b) Education for members by the Case Manager on using the 24-hour line will be included at the assessment home visit.

c) Access to the following services will be provided or facilitated via the 24-hour phone line:

(1) After-hours medical triage and advice
(2) After-hours medical consultation by SOURCE Primary Care Provider or designated qualified medical professional
(3) Assistance in resolving service delivery complications, after hours
(4) Authorization of medical services

d) Authorization of community services including increase or decrease in service (also using the site-specific SOURCE number) must be approved by Case Management staff, with confirmation on the appropriate forms.

1404. Member Discharge

Discharge **Planning** Policy Statement:

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

Discharge planning is conducted to: Plan for continuity of an individual's health care; Maintain the individual's level of functioning; Lower an individual's readmission rates to medical facilities (for example: handrails in bathroom to prevent falls)

Process for Discharge **Planning**:

Complete the following activities at enrollment to ease planning at discharge:

Begin to develop the discharge plan during the initial assessment (document what the member will need if discharged)

Reflect discharge planning in care plans by utilizing the steps in 1401 that ensure maximize funding (i.e. keep family resources in place, use community resources)

Coordinate discharge planning in consultation with the client's physician, other involved service agencies, and other local resources available to assist in the development and implementation of the individual's discharge plan.

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See Discharge checklist form for more Information on operationalization of discharge planning.

Discharge Policy Statement:

SOURCE Members can be discharged for a variety of reasons. Voluntarily/Involuntarily.
SOURCE supports and when possible improves the member's functioning. If evaluation or occurrences support discharge, SOURCE will work to make the transition as smooth as possible.

Process for Discharge:

The Case Manager will exhaust all means to ensure that members continue their enrollment in the program, for several key reasons:

- Members constitute a vulnerable population due to chronic illness, disability, advanced age and low-income
- Managing non-compliance is a core function of the CM/Primary Care Provider team
- DCH expects sites to meet or exceed consumer expectations

Discharge from the program may be either voluntary or involuntary. Reasons for discharge include:

- Member moves from the site's service area
- Member does not meet eligibility using the definition in section 801.3 disability and Intermediate Nursing Home Level of Care Criteria
- Member is no longer eligible for full Medicaid
- Member death
- Member transfers to another waiver program
- Member is admitted to a nursing home (may hold for 100 days)
- Member Choice
- Member is chronically non-compliant (non-compliance includes continued abuse of alcohol or drugs)
- Member health and functionality is not confirmed by the Primary Care Provider's documentation or other appropriate physician specialist

This section is appended by Section 1406, Right to Appeal.

a) Voluntary Discharge
Enrollment in SOURCE is strictly voluntary. Case Managers will make all feasible efforts to meet the reported and observed needs of persons in service. However, a voluntary discharge will be effective immediately as of the date requested by the member, guardian or custodial caregiver.

Procedures:

(1) A Case Manager's efforts to reconcile the source(s) of a member with the program may include as indicated:

- Conferences with providers, Case Manager and members/ Caregivers
- Changing provider, PCP or Case Manager
- Discontinuing an individual service or otherwise altering the Care Plan

(2) If efforts to resolve a member's or caregiver's dissatisfaction with SOURCE are unsuccessful, the consequences of disenrollment from SOURCE will be explained:

- Case Management services from site discontinued
- Community services reimbursed by SOURCE discontinued

(3) If other HCBS programs are enrolling the member following discharge from SOURCE, the Case Manager will work to make the transition happen smoothly.

(4) Services reimbursed by SOURCE will be discontinued effective on the date so requested by the member, or the date the member becomes ineligible.

(5) Upon learning of an effective discharge date, the Case Manager will notify:

- SOURCE providers, by completing the Discharge section of the EDWP Notification Form (ENF)
- Providers not reimbursed through SOURCE

- The SOURCE PCP office

(6) The member's PCP may continue providing primary care services following discharge from the program if requested by the member and agreed to by the PCP.

(7) Upon discharging the member, the Case Manager will complete the SOURCE Discharge Summary Form in its entirety, and Form 5382 EDWP Discharge Form to be mailed to the member and to be filed in the member's chart. **Once discharge of services occurs, make sure the Service Prior Authorization lines are end dated.**

1405. SOURCE MEMBER INVOLUNTARY DISCHARGE

I. Involuntary Discharge

The Effectiveness of SOURCE services depends heavily on the participation of members/caregivers in developing and implementing the Care Plan, Service Order, and task lists.

A prolonged or repeated pattern of deliberate non-compliance may result in involuntary discharge of the member from the SOURCE waiver program. However, a member's involuntary discharge from the SOURCE wavier program will not end the member's Medicaid eligibility.

Some examples of non-compliance will include, but are not limited to:

- A failure of the member to keep scheduled Primary Care Provider appointments
- The member actively or intentionally avoiding or refusing Case Manager visits or other contacts
- The member's refusal to allow and/or facilitate the delivery of community services as agreed on in the Care Plan.
- A failure by the member to provide essential information affecting SOURCE's ability to help members live in healthy and functionally independent ways
- A member who refuses to participate in problem solving discussions and efforts with Case Manager's, PCP's, physicians or providers around Care Plan variances, delivery or clinical issues
- A member's failure to use designated SOURCE providers or affiliates for services

Only after thorough efforts by the site to resolve any patterns of non-compliance of the member will SOURCE waiver programs benefits be sought to be involuntarily discharged.

Discharge will occur when:

1. The case manager determines that the member is no longer appropriate or AHS deems ineligible for services under SOURCE

2. DCH staff recommend in writing that a member be discharged from service

3. Member/member's representative consistently refuses service(s)

4. Member's physician orders the member's discharge from SOURCE

5. Member enters a medical facility. (The provider may decide to send the notice of discharge immediately upon the member's placement in a medical facility or in the case of facility admission expected to be 100 days or less the Case Management Agency may suspend the Service Prior Authorization, Assessments, Care Plan, etc.)

6. Member allows illegal behavior in the home; or member or others living in the home have inflicted or threatened bodily harm to another person within the past 30 calendar days.

7. Member/member's representative or case manager requests immediate termination of services. The provider must document in the member's record the circumstances that led up to termination.

8. Member moves out of the planning and service area to another area not served by the provider. (If requests a transfer of services, this needs to be coordinated by case management to ensure continuity of care)

9. Member expires.

10. Provider can no longer provide services ordered on the Care Plan. (see also section 1306 Discharge… initiated by the provider)

11. Member is non-compliant. Examples of non-compliance includes:

    a. Failure to keep scheduled Primary Care Provider appointments
    b. Avoiding or refusing Case Manager visits or other contacts
    c. Refusal to allow or facilitate the delivery of community services as agreed on in the Care Plan.
    d. Failure to provide essential information affecting SOURCE's ability to help members live in healthy and functionally independent ways
    e. Refusing to participate in problem solving discussions and efforts with Case Manager's, PCP's, physicians or providers around Care Plan variances, delivery, or clinical issues
    f. Failure to use designated SOURCE providers or affiliates for services

II. Procedures for Discharge:

For a member to be involuntarily discharged the following must occur:

1. The assigned Case Manager will communicate clearly at admission the program's expectations of members/caregiver

2. The Case Manager will state that program eligibility requirements and reevaluation is needed to remain on the SOURCE program

3. Single, minor, or isolated instances of non-compliance will not result in formal action; the Case Manager will address these issues with members/caregiver as they occur.

4. The Case Manager will take steps indicated for repeated instances of non- compliance, involving as indicated the member's PCP, supervisor or program manager.

5. Issues of non-compliance and efforts at resolution will be documented in the member's case notes, on the Care Plan.

6. The multidisciplinary team staffing the admissions process will be the entity to hear, explore and decide issues of pending discharge due to non-compliance

7. The Primary Care Provider will be informed of pending involuntary discharge prior to the disenrollment's effective date. Prior to discharge, a member (or custodial caregiver or guardian) will receive from the

Case Manager – following approval by the site's multidisciplinary group – written warning of potential discharge with a suggested course of action required to avoid discharge.

8. For members/caregiver unable to read, the Case Manager will read the letter over the phone or in person; the letter will also be mailed to the member's house.

9. Should the first written warning fail to resolve a pattern of non-compliance, members (or custodial caregivers or guardians) will receive from Case Manager (with approval from the multidisciplinary group) a written deadline for the course of action necessary to avoid discharge.

10. If the member fails to meet the letter's deadline, the Case Manager will initiate steps to discharge.

11. The Case Manager will make referrals to other programs or agencies if the dis- enrolling member so requests.

12. The Case Manager will facilitate the transition to other agencies in all ways possible.

13. Members will be informed in writing using the EDWP 5382 Form of the formal date of discharge from SOURCE.

Members may further seek to appeal an involuntary discharge through the Department of Community Health's appeal process**.**

Members may be involuntarily discharged immediately from SOURCE by the site's multidisciplinary staff group for criminal activities by member or in the home, and physical aggression toward providers, CM or PCPs, by member or in the home environment bypassing procedures 3 through 13.

Upon discharging the member, the CM will complete the SOURCE Discharge Summary Form in its entirety to be filed in the member's chart.

Level of Care PAs will not be terminated and left open until they expire.

End date all the Service Prior Authorization lines with appropriate date.

III. Procedures for Suspension of Service Prior Authorization

For suspension of services which will allow a member's Service PA to be reactivated and maintain LOC Prior Authorization the CM and PA builder should take these steps:

1. End date all Direct Service Provider (DSP) Lines with the date the member entered the Medical
2. Facility (please do this after checking to make sure DSP billing dates are in alignment with the end date desired)
3. Leave Case Management Service line date to mirror Service Prior Authorization end date. (This will signal to AHS that the Case Management agency has not terminated the member. Member is in suspense)

1406. Right to Appeal

A. SOURCE members and applicants have the right to appeal the following actions of a SOURCE Enhanced Case Management site:

1. The DON-R score (but may not appeal agency refusal to screen assess based on initial information)

2. Denial of eligibility (category of eligibility other than SSI or Public Law or no category; failure to meet nursing home level of care; refusal based on other factors like service area, available housing, safety concerns, etc.)

3. Reduction in services (any reduction in service, even resulting from a temporary increase)

4. Termination of services (discharge from SOURCE)

The Department of Community Health will notify sites when a request for an appeal is made, and when a request is made to maintain services at the current level.

B. Agencies are not to reassess a client while the client is under an appeal request or Request for Fair Hearing (RFH) unless;

1. Greater than nine (9) months since last assessment (waiver requires annual assessment) and appeal if for a reduction of services or termination for an action other than Level of Care Denial
2. Requested directly by an Attorney from DCH Legal Services Department

Sites should note that this policy applies only to SOURCE-reimbursed services.

Procedures for Issuing Discharge Notice from Case management Agency for other than Level of Care Denial from Alliant:

Case managers and CM supervisors will attempt to reach consensus with members and potential members (or legal guardians if applicable) on decisions made about the member's care. SOURCE sites will involve the primary care physician and/or Medical Director in all decisions resulting in adverse action.

Members who fail to meet the eligibility criteria at screening will be reviewed by the Interdisciplinary team prior to issuance of the A Denial, Termination, and Reduction in Service form 5382. The screening nurse will present, or, at a minimum, be available to answer questions about the member's DON-R to the interdisciplinary team for review and discussion.

If the team agrees that the member does not meet eligibility, the Medical Director will indicate same in item 34 of SOURCE Level of Care and Placement Instrument and sign his/her name as required.

1. Following discussion of an action falling into any of the categories described above, the site will inform the member clearly of the action to be taken.

2. Sites will give the member written notice, sent via Certified Mail, of actions for any of the categories, using the NOTICE OF DENIAL, TERMINATION, and REDUCTION IN SERVICE. The form will be dated the day the form is mailed.

3. Sites are not to issue a discharge letter if AHS has issued the decision. Sites may download AHS's written notice from the AHS web portal and take to client if client is not aware of notice or has not received notice through mail.

4. The original Denial, Termination, Reduction of services letter is mailed to the SOURCE member via Certified Mail, along with the Notice of Right to a Hearing form. After conferring to the member, the Discharge Summary is completed. A copy is kept in the SOURCE chart.

For members concurring with the intended action, the same procedure is followed.

5. Members have 30 days from the date of their EDWP Discharge Form 5382 to request a hearing in writing; in cases of decreasing or terminating services, members may retain their

services at their current level by notifying DCH in writing within thirty days of the EDWP Discharge Form 5382 date. Services remain in place pending the outcome of the Administrative Hearing.

6. **(***Discharge to nursing home does not require a 30-day waiting period after the "Z" (Discharge, Termination) letter is sent; once Case Management decides it is appropriate to discharge the NH member from the Waiver, it is immediate. Refer to Section 1405-Involuntary Discharges*)

7. Case managers should follow up the EDWP Discharge Form 5382 with a call within 15 days to determine if the member (or legal guardian if indicated) has any questions concerning the adverse action notice. (See Step 3 if member has not received notice)

8. If the member wishes to appeal, the case manager should assist with their request for a hearing as appropriate.

9. The case manager should ensure the member has information on obtaining assistance in appealing an action (see EDWP form 5381, Notice of Right to Appeal Decision).

10. The Case Manager will check with the member and/or family representative regarding the notice of adverse action and whether a hearing request has been filed with DCH before formally discharging the member from the program.

11. Members requesting discharge from SOURCE are exempt from the 30-day waiting period. Case Managers should immediately send in a SOURCE Level of Care and Placement Instrument form with the date requested for discharge by the member. The member will no longer receive SOURCE EPCCM or community-based services as of the date indicated on the SOURCE Level of Care and Placement Instrument. See also Policy No.1405 (a) Voluntary Discharge.

12. A SOURCE member has the right to represent him/herself or have an attorney, paralegal or any other person to represent him/her. Case managers should notify members of the availability of local services for legal assistance to older or low- income persons.

13. If an appeal is filed by the members, the site will present information at the appeal supporting the adverse action taken.

14. Additionally, the Interdisciplinary team, with the case manager, will view other resources to meet the member's needs. Appropriate discharge planning and referral assistance will be provided to the member by the case manager throughout the thirty-day notification period.

15. CM will notify member of the planned discharge and provide the member with information

regarding the appeal process, as directed in Medicaid Part I Policy and Procedures section 500.

NOTE: Prior to review by the Interdisciplinary team, the nurse (RN or LPN) shall review the member's diagnoses, medications, treatments with the member's PCP to ensure concurrence with Member's health and functional status as documented on the MDS-HC.

Procedures after decision Alliant Level of Care Denial:

1. SOURCE assessment nurse (R.N. or LPN) will carry out the MDS HC assessment and the RN will upload the assessment packet to Alliant Health Solutions. If AHS determines that the member does not meet eligibility, the denial letter will be issued to the member from Alliant . The Denial Letter states why the member does not meet the LOC criteria and cites applicable policy. The member has thirty (30) days to request a hearing.

2. Discharge planning information/resources are sent to the member within 15 days of denial.

3. A second level review option is available to members who have a AHS issued denial. This means that:

    a. If the member provides new information in the 10 days, they will either be accepted by AHS for LOC, or they will receive a 2nd and final denial letter.
    b. The member will have 10 business days to provide new information to AHS through their Case Management agency.
    c. If the member provides new information in the 10 days, they will either be accepted by AHS for LOC, or they will receive a 2nd and final denial letter.

    d. If the member does not give new information, no new denial letter will be issued from AHS. The member continues to have the right to ask for an appeal 30 days from issuance of the original denial letter

4. If the member requests a hearing, the member will send his/her hearing request to DCH Legal Services.

5. Upon receipt of the hearing request, DCH Legal Services will decide to accept or reject the request for hearing. If accepted DCH will:

6. Send the member a confirmation letter that the hearing will be granted,

7. Contact AHS to request a copy of the file/records used to make the eligibility determination,

8. Documentation of paperwork from steps 4 or 5, AHS confirmation, or a memo from DCH SOURCE confirming the hearing request was granted will confirm that Level of Care is to be continued under the DCH Legal Services authority (and services are to continue) for Utilization Review or Program Integrity. A copy must be sent to the providers for their

records to continue services.

9. SOURCE Program site or AHS will provide a copy of the records to DCH Legal Services.

10. The benefits must continue.

11. If member's Prior Authorization has expired, AHS will extend the LOC PA for four (4) months if they have denied the member.

12. If the hearing is withdrawn with an agreement for a referral to another waiver, the new LOC PA will be approved for an extension and the new LOC must be signed by the Medical Director.

13. Upon receipt of the records, DCH Legal will assign the case to an attorney and transmit the case to OSAH for a hearing. OSAH will issue a notice of hearing setting a specific hearing date, time, and location.

14. While waiting for the hearing to occur, the benefits must continue, and monthly and quarterly contacts must be made.

15. During this waiting period, if the member decides that he/she does not want to proceed with the hearing, it is the member or the member's representative's duty to inform DCH And OSAH that the member no longer wishes to proceed with the hearing. SOURCE does not represent the member. SOURCE is not an agent of the state. The right to a hearing belongs to the member.

16. If the member decides to proceed with the hearing, the administrative hearing will occur and the administrative law judge will issue a decision. Continue member benefits pending the judge's decision.

17. If the judge rules in favor of DCH, the member's benefits will be terminated. The member can appeal to the next level. Keep ruling with member file.

18. If the judge rules in favor of the member, the benefits will continue and DCH can appeal to the next level. Maintain a copy of the ruling with the most current SOURCE Level of Care and Placement Instrument. Annual Reassessment following an appeal is determined by the Prior Authorization dates. The time spent in hearing will count to the annual review.

Note: In the case of SOURCE terminations upheld through hearing, or in the case of voluntary terminations, SOURCE case management agencies notify all HCBS provider agencies involved in the provision of services to the member in order to avoid continuation of services not reimbursable under Medicaid.

IF	THEN
Technical Denial	When part of the required paperwork in not uploaded, you receive a technical denial.
Final Technical Denial	**This is rendered when the paperwork not uploaded within 30 days**
Initial Approval	When the LOC is complete and meets Level of Care criteria upon nurse review

Initial Decision/Denied	Rendered when the LO is complete but does not meet the level of care/policy guidelines upon initial nurse LOC review.
Second Level Nurse Review	Member may request a reconsideration of this decision by sending additional medical information to the Case Management office within 10 days of the date of the Notice of Denial/ Termination and within 20 calendar days to Alliant.
Approval/Denial	Standard approval is issued if based on the new information submitted the client meets the Level of Care criteria. A denial is issued if the based on the new information still does not meet LOC criteria
If a denial is issued by Alliant and client wants to appeal the decision	If the client requests, either orally or in writing, appeal of decision within 10 days of the date of the notice of adverse decision by Alliant, and requests that services continue while hearing is pending, services will continue until there is an administrative decision. Client must request an appeal in writing within 30 days of the date of notice of the adverse action, Send letter to: Department of Community Health Legal Department 2 Peachtree Street, 40th Floor Atlanta, Georgia 30303-3159
If a denial is issued by Alliant and the client does not choose to appeal	Then services will continue until the current level of care expires.
Legal accepts the appeal letter, the current PA will be extended for 4 months.	Alliant will extend the current LOC PA for another 4 months. The Physician notification letter and order for extended services is sent to the Physician or signed by the Medical Director at the next team meeting. Case Management will end the Service PA and build a new one for the four months of the hearing extension.

1407. Confidentiality of Member Information

Integration of care for chronically ill people requires significant sharing of information between key players. To a greater extent than conventional HCBS, SOURCE Case Management Provider access, review and maintain patient records of all types, due to:

- Increased accountability standards for CM, across all treatment settings
- Coordination with participating primary medical care providers
- Formal linkages with health system providers

Ensuring appropriate access to medical and case management information by individuals involved in direct care or in monitoring care must be balanced with concern for member privacy. Offenses of confidentiality fall into two categories: **unauthorized access** of confidential data (looking at a member's chart or other data when there is no "need to know)," and the **unauthorized use, dissemination or communication** of clinical or other confidential data.

SOURCE Case Management Providers are required to act in accordance with the Health Insurance Portability and Accountability Act (HIPAA).

Procedures:

a) Each site will maintain a confidentiality policy specific to the organization.

b) The site-specific policy will include an "Employee Statement of Confidentiality" with disciplinary actions described for policy violations.

c) Upon admission, all members will sign a consent form to permit the release of information, as necessary to individuals or entities participating in the program.

d) Only case management, medical records and administrative staff will have direct access to member charts, excluding regulatory agency staff.

e) Charts will be maintained after hours in a secure environment.

f) Release of information to participating providers will be only on an as needed basis, and according to the policies and procedures of the site and DMA.

g) All charts will be maintained per the guidelines as specified in Part I Policies and Procedures for Medicaid/Peachcare for Kids

1408. Non-Reimbursed Items and Services

In helping members continue residing in the community, CM will frequently discover needs for items or services not covered by conventional third-party payers like Medicaid or Medicare or by other traditional community resources. Often these items or services are critical to achieving Care Plan outcomes for members, but the costs may be far out of reach for the member/caregiver to pay for privately. Sites will develop or have access to funds to bridge gaps in coverage for essential items or services. Typical examples include incontinence supplies, nutritional supplements and certain prescription medications; other examples are moving expenses, pest control, specific pieces of DME, etc.

If funds for non-covered items or services do not exist in the local community, a site may consider applying to local charitable foundations, accepting donations from civic organizations, individuals, churches, and other faith-based organizations, etc., to build a fund. Sites must comply with all applicable local, state and federal requirements.

Payment for such items or services by the site does not set a precedent for such funding for all members. Consideration should be on an individual, case-by-case basis and will depend on the amount of funding and guidelines established.

Procedures:

a) The Case Manager will review any available options to cover a needed item or services, including the member/caregiver's own resources.

b) When other potential sources are ruled out, the Case Manager will submit a request in writing to the Case Manager Supervisor documenting specifically the service or item needed a time frame if applicable and a brief rationale.

c) The Case Manager Supervisor or Program Manager will have authority to approve the expenditure and will maintain a record of all items/services covered.

d) The Case Manager will forward the approved request to the organization or staff member (if internal) in charge of dispersing funds.

e) If the items/services are not approved, the Case Manager will continue to work with the SOURCE member/Caregiver to attempt to obtain the item or services from other sources or to find a suitable substitute.

f) For items/services funded on an ongoing basis, the Case Manager assigned will be responsible for reviewing every quarter the need for continued assistance.

g) Non-reimbursed services for members will be documented, for potential analysis of service packages.

1410. HIPAA Regulations

A federal law about health care, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), provides new health privacy regulations.

The Privacy Rule under HIPAA establishes privacy protections that assure Medicaid recipients and all health care patients that their medical records are kept confidential. The rules will help to ensure appropriate privacy safeguards are in place as we manage information technology to improve the quality of care provided to patients. The new protections give recipients greater access to their own medical records and more control over how their personal information is used by their health insurance plans (including Medicaid) and by health care providers.

The DCH Notice of Privacy Practices explains how Georgia Medicaid uses and discloses individuals' health information and how individuals may access their information. The notice

was mailed to all Medicaid recipients with the April 2004 eligibility cards.

Chapter 1411 – Reporting and Investigating Incidents

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

One form may be used to record multiple incident types if they relate to the same overall incident.

When an incident involves more than one waiver member, an incident report must be completed for each waiver member.

See below for definitions of reportable incident types.

Reporting of Incidents

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

1. Providers must immediately take steps necessary to protect the waiver member's health, safety and welfare upon witnessing or discovering an incident.
2. The provider will immediately notify:
    a. The individual's guardian and/or next of kin, as legally appropriate:
        i. Notification of incident with a severity ranking of 3 and above shall occur within two (2) hours.
        ii. Notification of all other incidents shall occur within twenty-four (24) hours.
    b. If the event occurred in an unlicensed facility/agency, Law enforcement and Adult Protective Services in instances of suspected abuse, neglect and/or exploitation of the member.
    c. If the event occurred in a licensed facility/agency, Law enforcement, Healthcare Facilities Regulation Division, and the Long-term Care Ombudsman in instances of suspected abuse, neglect and/or exploitation of the member.
    d. If instances of suspected abuse, neglect and/or exploitation of a member who is a minor, Law enforcement and the Child Protective Services.
3. The provider will submit the Incident Report electronically via the webform located at the instructions on the location of the form on the DCH website within twenty-four (24) hours of the incident, or the discovery of the incident, but no later than one (1) business day if the incident occurred after business hours or on a weekend or holiday.
4. A confirmation email with a summary of the incident will be sent to the reporting provider, the contact person identified, and the member's case manager if they are not the reporting provider.
5. In all cases of suspected abuse, neglect or exploitation follow-up on referrals to law enforcement and regulatory authorities until resolution.

Follow-Up and Intervention Reporting

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

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

a. Investigate the cause of the incident

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

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

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

d. Participate in regulatory agency investigations, if applicable

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

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

Incident Types Definitions

	Definition

Injury Severity Ratings:	1 - No injury (no treatment required) 2 - Injury requiring first aid (small adhesive bandages, cleaning of abrasion, application of ice packs, over the counter medications as physician ordered) 3. Injury requiring treatment beyond first aid (medical treatment required by a licensed practitioner - MD, NP, PA, etc. that is not serious enough to warrant hospitalization, such as sutures, broken bones, prescriptions etc.) 4. Injury requiring hospitalization (medical intervention and treatment at a hospital, including stays for observation only) 5. Death 6. Refused treatment
Death - Expected	Cause of death is attributed to a terminal diagnosis or diagnosed disease process identified more than 30 days before the date of death, where the reasonable expectation of outcome is death, there is no indication that the individual was not receiving appropriate care.
Death - Unexpected	Death due to any cause where the cause of death is not attributed to a terminal diagnosis or diagnosed disease process where the reasonable expectation or outcome is death, does not meet the definition of an expected death. Examples include but not limited to death from suicide, homicide, medication errors, undiagnosed condition, criminal activity, an accident, or possible abuse or neglect.
Suicide Attempt resulting in injury	Self-inflicted harm due to failed suicide attempt. Injury severity scale 2, 3, and 4.
Alleged Abuse - Physical	The willful use of physical force to coerce or to inflict bodily harm, pain or mental anguish. Indicators of physical abuse may include, but are not limited to, rough handling, improper use of restraints, injuries not consistent with medical diagnosis or explanation, or unreasonable confinement.
Alleged Abuse - Sexual	Any kind of sexual behavior directed towards an individual without their full knowledge and consent. A spouse, partner, family member or other trusted person can perpetrate sexual abuse. Indicators of sexual abuse include, but are not limited to, any nonconsensual sexual contact, inappropriate touching, forced viewing of sexually explicit materials, sexual harassment or sexual assault.

Alleged Abuse - Psychological	Using tactics, such as harassment, insults, intimidation, isolation or threats that cause mental or emotional anguish. It diminishes the person's sense of identity, dignity, and self-worth.
Alleged Abuse - Verbal	Verbal abuse is any use of oral, written or gestured language that may be threatening, demeaning, discriminatory, or insulting regardless of their age, ability to comprehend, or disability.
Alleged Neglect	Failure to provide essential services (food, water, shelter, medical, etc.) that cause actual or potential physical or medical harm, mental anguish, or mental illness.
Alleged Self-Neglect	Failing to perform essential self-care such as depriving oneself of necessities such as food, water, or medication. Consciously putting oneself in harm's way or being unable to handle needs of day-to-day living because of medical, mental health or other disabilities.
Alleged Exploitation	Evidence of deliberate intent to manipulate an individual for personal benefit or self-advancement.
Alleged Financial Exploitation	Evidence of deliberate intent to misuse funds or assets of an individual for personal benefit or benefit of another. Examples include, but are not limited to, theft, forgeries, unauthorized check-writing, unexplained disappearance of cash or valuable objects, misuse of an insurance policy, or identity theft.
Accidental Injury	Injuries to individuals with a known cause that were not a result of aggressive acts to self or others.
Fall - Accidental	Uncontrolled, unintentional, downward displacement of the body to the ground or other object.
Fall - Purposeful	Willful intent of an individual to cause downward displacement of the body to the ground or other object.
Fall - Medical condition	Uncontrolled, unintentional, downward displacement of the body to the ground or other object due to a medical condition.

Choking with intervention	An incident of choking that required intervention to clear the airway. Choking is defined as any episode of airway obstruction by food or foreign object as evidenced by one or more of the following: a) inability to speak when asked if choking (if individual is verbal); b) inability to breath or difficulty taking in adequate breaths; c) movements indicating distress such as grasping for neck or throat; d) turning blue.
Medication Error with Adverse Consequences	A failure in the medication process that results in a significant adverse reaction requiring medical attention in an emergency room, urgent care center, or hospital. Errors include but are not limited to: omission of a medication, wrong dose, wrong time, wrong person, wrong medication, wrong route, and/or wrong position.
Medication Error without Adverse Consequences	A failure in the medication process that does not result in harm. Errors include but are not limited to: omission of a medication, wrong dose, wrong time, wrong person, wrong medication, wrong route, and/or wrong position.
Hospitalization - Medical	Any admission to a hospital, either directly or through a facility's emergency room.
Hospitalization - Psychiatric	An unplanned, involuntary admission of an individual to a psychiatric treatment facility.
ER Admission	Any admission to an emergency room.
Aggressive Act for all three types (member against member, member against non-member, staff against member)	Aggressive act resulting in injury of severity ranking 3, 4, and 5.
Seclusion or Restraint	The use of physical holding and mechanical restraints and/or solitary confinement of member, which are prohibited per waiver policy.
Elopement - Greater than 30 minutes	A cognitively impaired person who successfully leaves unsupervised and undetected from a residential location or day program.
Alleged Criminal Act by a Member	Conduct that could result in criminal proceedings.

Violation of Individual Rights	A denial of an individual's rights without good cause regardless of age, race, sex, nationality, ethnicity, sexual orientation, language or religion. Examples include but are not limited to: a denial of individual's rights without the benefit of due process, breaching an individual's confidentiality, purposely allowing an individual's privacy to be invaded or breached, denial of access to the Patients' Rights Advocate, and denial of legal representation.
Environmental Threat	An event with direct impact on member health and safety occurring within or around a residential location or day program. These events can result in but are not limited to mortality, illness and/or injury, and disrupts living arrangements requiring intervention or relocation.
Media Alert	An incident that may have significant impact upon, or significant relevance to, issues of DCH public concern and/or are likely to be reported in the media.

1413. Case Management Reimbursement Hierarchy

Note: Duplication of Case Management Services

Federal policy and the Department of Community Health (DCH) prohibit the reimbursement for repetitive case management services to more than one agency or Medicaid provider that renders case management services to an individual. (Guidelines for dual enrollment in SOURCE and acceptable non-repetitive Case Management are in section 701 Member Exclusions)

- A hierarchy (see below) for case management services was established to prevent payment of more than one case management services per month.
  1. COS 830 – CMO
  2. COS 930 – SOURCE
  3. COS 680 - MRWP/NOW
  4. COS 681 - CHSS/COMP
  5. COS 660 – ICWP
  6. COS 590 – CCSP
  7. COS 764 – Child Protective Services Targeted Case management
  8. COS 800 – Early Intervention Case Management
  9. COS765 – Adult Protective Services Targeted Case Management
  10. COS763 – At Risk of Incarceration Targeted Case Management
  11. COS762 – Adults with AIDS Targeted Case Management
  12. COS790 – Rehab Services/DSPS
  13. COS100 – Dedicated Case Management – Non-Waiver Members
  14. COS840 – Children's Intervention Services

Effective for dates of service on and after January 1, 2009, the Case Management agency or Medicaid Provider submitting claims for the same member in the same calendar month:

- If two claims are submitted for CM services the hierarchy determines which provider will be paid.
- If the lower hierarchy provider has been reimbursed the claim amount will be recovered and payment made to the CM provider first in the hierarchy.

1414.0 Conflict Free Case Management

The Balancing Incentive Program (BIP), authorized by Section 10202 of the 2010 Affordable Care Act (ACA), is being transitioned into Georgia. BIP aims to improve access to community-based long-term services and supports (LTSS).BIP includes Conflict-Free Case Management (CFCM).

How this affects SOURCE Case Management Agencies:

As a care/case management entity, you are required to adhere to the following characteristics of conflict-free case management:

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

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

- ***Case managers do not establish funding levels for the individual:*** In the Georgia model, the care coordinator/manager's responsibility is to develop a recommended plan of supports and services based on the individual's assessed needs. Ultimately, DCH staff and its agent (AHS/Alliant) will determine whether the care plan is medically necessary.

  (For SOURCE, funding level is set by the waiver, and individual funding is ultimately under the approval of DCH for medical necessity, this will be reinforced with training to Case Management Agencies.)

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

A plan from each care management entity that identifies its strategies for conflict-free case management should be included in all company policy manuals.

If you feel your agency is the only provider supplying care coordination and direct support services for an area, please notify DCH for further direction.

If DCH agrees, you will need to identify the protections that are engaged to mitigate conflicts of interest. Each plan should also speak to the development of a written protocol that would be applied operationally to support the adherence to policy.

1415.0 Consumer Directed Option

The Department of Community Health, Home and Community Based Services Medicaid Waiver offers a Consumer-Directed Services option for Personal Support Services (CD-PSS). CD-PSS supports client choice and independence and promotes increased client participation in care planning and budgeting, service delivery, and the freedom to hire, supervise and train his/her PSS care giver. All other EDWP Waiver services, identified on the CarePlan, are provided by enrolled provider agencies.

Information about the Traditional/ Enhanced EDWP and CD-PSS is available through local Area Agencies on Aging, ADRC Services, and EDWP Case Management agencies. Written information is available in the EDWP Fact Sheet Brochure. New clients and families receive information about the Consumer Direction option at Intake and Screening and again during the face to face Initial Assessment. Clients currently enrolled in the EDWP and appropriate for PSS will be educated about the new option during each Comprehensive Care Plan Review.

See Part II- Chapter 1800 Policies and Procedures for Elderly and Disabled Waiver EDWP-Traditional and Enhanced Case Management sections 1872-1876 for more information.

1416.0 Standard of Promptness Guidelines

Standards of Promptness Guidelines

Standard of Promptness for Care Coordination	
IF ACTIVITY IS	**THEN STANDARD OF PROMPTNESS IS WITHIN**
Responding to telephone inquiry regarding SOURCE admission	3 business days after telephone inquiry
SCREENING	
Screening a referral	3 business days after telephone inquiry
Notifying client referral source of client denial/ineligibility determination at screening	Within 3 business days after decision of non- eligibility
INITIAL ASSESSMENT	
Nurse completion of face-to-face assessment for new admissions	within 15 business days of notification of slot availability
RN review of the assessment	10 business days following the assessment visit
Sending assessment /reassessment package to AHS for LOC review	Immediately following RN Review
Send ECM DM Physician Letter to PCP	Following approval of PA by AHS and every 6 months after
REASSESSMENT	
Start Reassessment Process and Send Reassessment package to AHS for LOC review	90 days before expiration of the current Level of Care reassessment begin redetermination process.
RN review of the assessment	10 business days following the assessment visit
Medical Director/PCP signature confirming LOC	Within 90 days of the member signature on LOC or 10 business days after a member's appeal has been granted by the judge and LOS extended by Alliant
Completing reassessments when requested by:	5 business days after reassessment request

Standards of Promptness

IF ACTIVITY IS (cont'd.)	THEN STANDARD OF PROMPTNESS IS WITHIN (cont'd.)
Sending referral packet to provider	Before service provider begins services
Completing and returning Member Information Form (MIF) to provider	3 business days after receipt from provider
Telephone contact with member	Monthly
Face to Face Care Plan review	Quarterly
Provider meeting for the coordination of care (Applies to all ALS, ADH, and PSS providers)	Twice a year Note: may be conducted face to face, telephone or electronically
Reporting Critical Incidents and Follow ups	Using the state electronic notification system within 24 hours of notification of the incident. If incident rported by Provider, case management has 7 days to investigate and fill out the follow up electronically. Update Care Plan with any changes
Transfer of client record when client moves to another EDWP site with the MDS, Level of Care and Placement, and 6 months case notes (copy of records is acceptable)	5 business days after notification of transfer
Submitting Monthly Statistical Reports to DCH	By the 15th of the month following the month subject to report
Involuntary Discharge	
Complete and provide a copy of the discharge plan with specific resources to the member	No later than 15 days following a SOURCE involuntarily discharge (day of notification by AHS or date the CM agency issued letter to member)
Follow up call or visit to member and or family to confirm understands information on discharge and discharge planning resources	7 to 10 work days after discharge plan is given