



# *Community Choices Waiver (CCW) Quick Start Procedures Manual*

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State of Louisiana  
Office of Aging and Adult Services (OAAS)

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OAAS Procedural Manual.*

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## 1.0 PROCESSING WAIVER CASES

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### 1.1 LINKAGES

#### 1.1.2 COMMUNITY LINKAGES

When an individual accepts a waiver offer, the chosen Support Coordination Agency (SCA), OAAS Regional Office (R.O.) and local Medicaid office is notified of linkage via email by the Data Management Contractor.

The SCA assigns the individual to a Support Coordinator (SC).

The SC will complete and send Admission 148-W to local Medicaid office and R.O.

The local Medicaid office begins the financial eligibility process. The SCA may be contacted to assist with this process (i.e. collection of documents, assisting with completing the Medicaid application, etc.).

**NOTE: The local Medicaid office is determining financial eligibility at the same time that the SC is determining the medical eligibility.**

If at any time in the approval/certification process, the individual does NOT cooperate with the SCA, the SC will:

- complete a narrative (including sufficient documentation to substantiate that the individual did not cooperate with the eligibility determination process) and document in the Case Management Information System (CMIS) and forward to SC supervisor.

The SC supervisor will:

- review and if appropriate, fax all documents to R.O. for approval or denial.

R.O. will:

- Review and verify that the individual did not cooperate with the eligibility determination process.
- Send out a denial notice to the individual with appeal rights and a copy to the SCA.

- If the individual appeals the decision, refer to the Appeals Procedures.

After the 30 days for appeal rights have passed AND the individual did NOT appeal, R.O. will complete a 142 (Refer to 142 Procedures) indicating “Not Approved – Does not meet Medicaid medical eligibility” and email/scan a copy to local Medicaid office, Data Management Contractor and the SCA.

The SC will close the case in CMIS.

### 1.1.3 NURSING FACILITY TRANSITION LINKAGES

After the SCA is notified of a nursing facility (NF) linkage, the SC will email the Eligibility Policy section in Medicaid state office and copy R.O., to determine if the individual will meet Medicaid financial eligibility outside of the NF. Both the SC and R.O. will be notified by return e-mail of the individual’s financial eligibility status.

#### **If the individual does not meet Medicaid financial eligibility outside of the NF:**

- The Medicaid office will issue a Decision Notice (Denial letter) giving appeal rights to the individual and copy R.O. and the SCA.

**NOTE: R.O. does NOT need to send a Waiver Denial Notice since the individual is being denied waiver services based on financial eligibility denial and adequate notice is being sent from Medicaid.**

- The SC will complete CMIS Closure form and fax to R.O.

R.O. will email/scan a copy of the Medicaid Decision Notice (Denial Letter) to the Data Management Contractor.

The SC will close the case in CMIS.

**NOTE: If the individual appeals the decision and wins the appeal, his/her Community Choices Waiver (CCW) case will be reinstated.**

## ***1.2 INITIAL VISITS***

The SC must:

- contact the individual and/or responsible representative within three (3) working days of receiving the Support Coordination Choice and Release of Information form to schedule a face-to-face initial meeting to complete the assessment.
- conduct a face-to-face meeting with the individual and/or members of his/her support network within seven (7) working days of receiving the Support Coordination Choice and Release of Information form to complete the assessment process.

**NOTE: The planning team may include anyone requested by the participant, but at a minimum will include the individual, his/her responsible representative (if applicable) and the support coordinator.**

During this meeting, the SC will:

- introduce him/herself to the individual;
- get to know the individual;
- provide information about the waiver program and eligibility processes;
- gather any necessary information;
- explain the Community Choices Waiver (CCW);
- explain all available services;
- explain Self-Direction;
- explain the range of services and supports available in the CCW;
- review and explain OAAS Rights and Responsibilities as a waiver participant;
- complete the Initial Minimum Data Set-Home Care (MDS-HC) (Refer to Initial Assessment Section & MDS-HC Manual);
- ask/complete the Degree of Difficulty Questions (if applicable);
- ask the individual about his or her support network (paid and unpaid) currently in place to determine how his/her needs are currently being met;
- complete the Caregiver Assessment (Refer to Caregiver Assessment Procedures.)
- explain the need for these paid supports to be supplemented with natural or paid supports, since waiver services are not available 24 hours per day;
- explain that the state is responsible for reasonably assuring the health and welfare of individuals with provision of these paid supports in conjunction with natural and other paid supports; and
- answer questions as simply and clearly as possible to so the individual understands the program requirements and services.

### 1.3 INITIAL VISITS FOR NURSING FACILITY TRANSITIONS

During this initial meeting for NF Transition individuals, the SC will **ALSO** explain the following:

- My Place LA (Money Follows the Person-MFP) and if interested in participating, have individual sign the MFP Informed Consent form.
- Transition services do not cover ongoing costs for housing and other basic needs (i.e. groceries, utilities, etc.).
- More services may be available initially when he/she comes out of the NF, but services may be decreased after he/she transitions out into the community (because services depend on needs).

The SC must:

- Meet with appropriate NF staff (i.e. Social Worker, Director of Nursing, etc.), ombudsman and family, as applicable, to review records and gather information for determining if the individual's needs can be met outside of the NF. This information may include, but is not limited to:
  - Does he/she have supplemental, natural and/or other paid supports available?
  - Does he/she have housing?
  - Does he/she have means for meeting other basic needs? (Discuss income and budget.)

Sources of information may include but are not limited to: the ombudsman, the Minimum Data Set-Nursing Facility (MDS-NF), the MDS-HC, progress notes and orders from all applicable disciplines.

**Once all assessment information is gathered, if it appears that the individual's health and welfare CANNOT be reasonably assured:**

- Documentation supporting the inability to reasonably assure health and welfare will be put in a detailed narrative and faxed to R.O.

**NOTE: Plan of Care (POC) does not have to be completed or submitted. However, based on the information obtained through the assessment and other sources, the narrative should address the issues described above (i.e., housing, adequacy of paid and unpaid supports, etc.) in detail why it is not felt that transition is NOT an option for the individual to transition.**

- R.O. will email all information for review to the Service Review Panel (SRP).
- If SRP determines that the individual's health and welfare cannot be reasonably assured, R.O. will send a denial letter with appeal rights to the individual and a copy to the SCA.

**NOTE: If POC was completed, R.O. will complete POC Action Section indicating date of SRP Referral and SRP findings.**

- After the 30 days for appeal rights have passed and the individual did NOT appeal, R.O. will complete a 142 (Refer to 142 Procedures) indicating "Not Approved – Does not meet Medicaid medical eligibility" and email/scan a copy to local Medicaid office, Data Management Contractor and the SCA.

The SC will close the case in CMIS.

**Once all assessment information is gathered and all good faith efforts to transition the individual have been exhausted and it appears that the individual will not be able to transition in a timely manner (due to housing issues, unable to obtain required documents, extended hospital/rehabilitation stay, etc. ), the SC will:**

- submit a detailed narrative to the SC Supervisor to support the inability to transition timely into the community. The SC Supervisor will review as to whether or not the individual's CCW slot is to be placed on "Inactive" status.

**NOTE: Plan of Care (POC) does not have to be completed or submitted. However, based on the information obtained through the assessment and other sources, the narrative should address the issues described above (i.e., housing, adequacy of paid and unpaid supports, etc.) in detail sufficient to document why the individual cannot transition timely out of the NF.**

- If the SC Supervisor's review results in a determination that all good faith efforts to transition the individual from the NF have been exhausted and documents such, the SC Supervisor will fax the information to R.O.
  - R.O. will approve or not approve the "Inactive" status request and notify the SCA of the decision via email.

- If “Inactive” status is NOT approved, the SC needs to continue to process the waiver case.
- If “Inactive” status is approved by R.O., the SC will:
  - issue an “Inactive” status letter advising the individual that transition activities will resume when barrier is resolved.
  - send a copy of the “Inactive” letter and narrative to R.O. & MFP (if applicable).
  - send 148-W with “Inactive” information to the Data Management Contractor and copy to R.O. & MFP (if applicable).

**NOTE: Even though the individual is on “Inactive” status, the SCA should continue to follow-up and work with the individual on identified barriers to assist in transitioning him/her into the community.**

- When barrier(s) is resolved, the SCA is responsible for completing the 148-W to change the individual’s CCW slot status from “Inactive” status to “Active” status and fax the 148-W to Data Management Contractor, R.O. and MFP (if applicable).

The SC will resume activities to transition the individual from the NF.

Once it appears that the individual’s health and welfare can be reasonably assured AND the barrier is resolved, the SC will proceed with the POC development (See Plan of Care Development Meeting Section).

## **1.4 ASSESSMENTS**

The Resident Assessment Instrument (RAI)-Minimum Data Set - Home Care (MDS-HC) is a comprehensive and standardized assessment used to evaluate the needs, strengths, and preferences of the individual for all initial, annual, status change, and follow-up assessments.

The MDS-HC assessment is completed with the individual in order to:

- verify that the individual meets level of care criteria;
- identify the individual’s needs;
- identify paid and unpaid supports (including family and community supports)

- determine the Resource Utilization Groups (RUGs) score, Activities of Daily Living (ADL) Index score, and corresponding Service Hour Allocation of Resources (SHARe) budget allocation;
- establish baseline information in regards to the individual's functional abilities;
- identify acute and chronic health conditions that may impact the individual's self-performance; and
- identify health and welfare concerns.

#### **1.4.1 COMPLETION OF THE ASSESSMENT/REASSESSMENT**

The MDS-HC assessment/reassessment, including the Degree of Difficulty Questions (DDQs) must be completed at a face-to-face visit with the individual by a certified assessor. For details on instructions for completing the MDS-HC assessment or reassessment, refer to the MDS-HC Manual and the Level of Care Manual.

**NOTE: Participants may request another MDS-HC Assessment/ Reassessment at any time.**

#### **1.4.2 CLIENT ASSESSMENT PROTOCOLS (CAPs)**

Specific items within the MDS-HC known as "triggers", link the MDS-HC to a series of problem oriented focus areas called "Client Assessment Protocols" (CAPs).

The CAPs triggers are guidelines to identify risk of decline. SC must complete OAAS -PF-10-005 Client Assessment Protocols Summary (CAPS). As the CAPS are worked they should be placed in the appropriate 4 key issue categories (Physical/Functional, Cognitive/Mental Health, Social Life, & Clinical Issues).

Plan of Care (POC) goals and interventions are derived through the person-centered planning process and are guided by the triggered CAPs to ensure that the individual is functioning at the highest practical level, improving functioning where possible and preventing/minimizing decline, or other threats to the individual's health and welfare.

### 1.4.3 INITIAL ASSESSMENTS

#### 1.4.3.1 INITIAL ASSESSMENT FOR INDIVIDUALS RESIDING IN COMMUNITY

The SC must:

- complete the MDS-HC assessment face to face with the individual and/or members of his/her support network within seven (7) working days of receiving the Support Coordination Choice and Release of Information form (Linkage Date).
- input the MDS-HC assessment into the database within three (3) working days from the completion date of the assessment.
- complete the Caregiver Assessment (if applicable). (Refer to Caregiver Assessment Procedures.)
- obtain the RUGs score, ADL Index score, and corresponding SHARe budget allocation.
- review the triggered CAPs and/or concerns identified on the assessment.
- determine if the individual meets nursing facility level of care (Refer to Level of Care Manual).
  - If the individual does NOT meet nursing facility level of care, the SC will complete a narrative (including sufficient documentation to substantiate that the individual does not meet LOC) and complete CMIS Closure form and fax to R.O.

R.O. will:

- Review and verify that the individual does not meet LOC.
- Send out a denial notice to the individual with appeal rights and a copy to the SC Agency.
  - If the individual appeals the decision, refer to the Appeals Procedures.

After the 30 days for appeal rights have passed AND the individual did NOT appeal, R.O. will complete a 142 (Refer to 142 Procedures)

indicating “Not Approved – Does not meet Medicaid medical eligibility” and email/scan a copy to local Medicaid office, Data Management Contractor, and the SCA.

The SC will close the case in CMIS.

Once all assessment information is gathered and it appears that the individual meets LOC, the SC will proceed with POC development. Refer to Plan of Care Development Meetings Section.

### 1.4.3.2 INITIAL ASSESSMENT FOR INDIVIDUALS RESIDING IN NURSING FACILITIES

The SC must:

- complete the MDS-HC assessment face to face with the individual and/or members of his/her support network within seven (7) working days of receiving the Support Coordination Choice and Release of Information form (Linkage Date).
- input the MDS-HC assessment into the database within three (3) working days from the date of completing the assessment.
- complete the Caregiver Assessment (if applicable). (Refer to Caregiver Assessment Procedures.)
- obtain the RUGs score, ADL Index score, and corresponding SHARe budget allocation.
- review the triggered CAPs and/or concerns identified on the assessment.

**NOTE: Individuals transitioning from a NF into a waiver slot are deemed to meet NF level of care regardless of the MDS-HC Assessment results; however they must meet all other program requirements. The SC must enter the following statement in the MDS-HC notebook: “Deemed to meet NF LOC eligibility due to current NF resident status.”**

**These individuals will be required to meet nursing facility level of care upon follow-up, status and/or annual reassessments.**

Once the assessment is completed and it appears that the individual can transition from the NF, the SC will proceed with the POC process (Refer to Plans of Care Development Section.)

#### 1.4.4 REASSESSMENTS

##### 1.4.4.1 FOLLOW-UP REASSESSMENTS

SCs are responsible for completing a Follow-Up MDS-HC Reassessment six (6) months from the date of the waiver certification (date participant was approved for CCW) for all participants that transitioned from a Nursing Facility.

**NOTE: If the six (6) month date falls on a weekend or holiday, reassessment should be completed on the following work day.**

**If the Follow-Up MDS-HC does NOT indicate that the participant meets NF LOC, the SC should proceed with discharge procedures.**

The SC must:

- complete the Follow-up MDS-HC reassessment face to face with the participant and/or members of his/her support network six (6) months from the date of waiver certification/CCW approval.

**NOTE: Provider(s) are not required to be at the reassessment meeting, UNLESS the participant requests the provider(s) to be present at the meeting.**

- input the MDS-HC reassessment into the database within three (3) working days of the date of the face-to-face follow-up reassessment meeting.
- complete the Caregiver Assessment (if applicable). (Refer to Caregiver Assessment Procedures.)
- obtain the RUGs score, ADL Index score, and corresponding SHARe budget allocation to see if different from previous MDS-HC assessment.
- review the triggered CAPs and/or concerns identified on the assessment to see if different from previous CAPs and/or concerns.

- determine if the individual continues to meet nursing facility level of care (Refer to Level of Care Manual).
  - If the individual does NOT continue to meet nursing facility level of care, the SC will complete a narrative (including sufficient documentation to substantiate that the individual does not meet LOC) and complete CMIS Closure form and fax to R.O.

R.O. will:

- Review and verify that the individual does not continue to meet LOC.
- Send out a discharge notice to the individual with appeal rights (including proposed termination in services notice) and a copy to the SCA.
  - If the individual appeals the decision, refer to the Appeals Procedures.

After the 30 days for appeal rights have passed AND the individual did NOT appeal, the SC will complete a 148-W (Refer to 148-W Procedures) and complete CMIS Closure form (including sufficient documentation to substantiate that LOC was not met) and fax to R.O.

**NOTE: SC should NOT send a copy of the 148-W to the local Medicaid office.**

R.O. will process the 148-W to close the case and will email/scan a copy to Data Management Contractor, local Medicaid office and the SCA.

The SC will:

- close the case in CMIS.
- notify the provider(s) by speaking to a representative and by fax on the same date that 148-W is received from R.O.

If it appears that the individual continues to meet LOC, AND RUGs score, ADL Index Score, triggered CAPs and/or concerns are same as previous MDS-HC assessment, the SC will review the current POC with the participant.

If it appears that the individual continues to meet LOC, AND RUGs score, ADL Index Score, triggered CAPs and/or concerns are different from the previous MDS-HC assessment, the SC will proceed with POC Revision to address the change(s) (Refer to POC Revision Section).

#### 1.4.4.2 CHANGE IN STATUS REASSESSMENTS

SCs are responsible for completing a Change in Status Reassessment when there is a significant status change in the participant's condition (Refer to Change in Status Checklist & Decision Making Guide).

If the SC determines that the participant has a Significant Status Change (SSC), the SC must:

- complete the Change in Status reassessment face to face with the participant and/or members of his/her support network on the fourteenth (14<sup>th</sup>) calendar day from the date of the notice of a change in the participant's condition.

**NOTE: If the fourteenth (14<sup>th</sup>) day falls on a weekend or holiday, reassessment should be completed on the following work day.**

**Provider(s) are not required to be at the reassessment meeting, UNLESS the participant requests the provider(s) to be present at the meeting.**

- input the MDS-HC reassessment into the database within three (3) working days from the date of completing the Change in Status reassessment.
- complete the Caregiver Assessment (if applicable). (Refer to Caregiver Assessment Procedures.)
- obtain the RUGs score, ADL Index score, and corresponding SHARe budget allocation to see if different from previous MDS-HC assessment/reassessment.
- review the triggered CAPs and/or concerns identified on the reassessment to see if different from previous CAPs and/or concerns.
- determine if the individual continues to meet nursing facility level of care (Refer to Level of Care Manual).

- If the individual does NOT continue to meet nursing facility level of care, the SC will complete a narrative (including sufficient documentation to substantiate that the individual does not meet LOC) and complete CMIS Closure form and fax to R.O.

R.O. will:

- Review and verify that the individual does not continue to meet LOC.
- Send out a denial notice to the individual with appeal rights (including proposed termination in services notice) and a copy to the SCA.
  - If the individual appeals the decision, refer to the Appeals Procedures.

After the 30 days for appeal rights have passed AND the individual did NOT appeal, R.O. will notify the SC to complete a 148-W (Refer to 148-W Procedures) and complete CMIS Closure form (including sufficient documentation to substantiate that LOC was not met) and fax to R.O.

**NOTE: SC should NOT send a copy of the 148-W to the local Medicaid office.**

R.O. will process the 148-W to close the case and will email/scan a copy to Data Management Contractor, local Medicaid office and the SCA.

The SC will:

- close the case in CMIS.
- notify the provider(s) by speaking to a representative and by fax on the same date that 148-W is received from R.O.

If it appears that the individual continues to meet LOC, AND RUGs score, ADL Index Score, triggered CAPs and/or concerns are same as previous MDS-HC assessment, the SC will review the current Plan of Care with the participant.

If it appears that the individual continues to meet LOC, AND RUGs score, ADL Index Score, triggered CAPs and/or concerns are different from the previous MDS-HC assessment, the SC will proceed with POC Revision to address the change(s). (Refer to POC Revision Section).

**NOTE: If the Status Change MDS-HC reassessment does NOT indicate a change in the participant's status, the SC should NOT complete a POC Revision.**

### 1.4.4.3 ANNUAL REASSESSMENTS

SCs are responsible for completing an Annual MDS-HC reassessment on all participants.

**NOTE: If the Annual MDS-HC reassessment does NOT indicate that the participant meets NF LOC, the SC should proceed with discharge procedures.**

The SC must:

- complete the Annual MDS-HC reassessment face to face with the participant and/or members of his/her support network no earlier than sixty (60) calendar days from the POC Expiration Date.

**NOTE: POC Expiration Date is the day after the POC End Date.**

**Provider(s) are not required to be at the reassessment meeting, UNLESS the participant requests the provider(s) to be present at the meeting.**

- input the MDS-HC reassessment into the database within three (3) working days from the date of completion of the annual reassessment.
- complete the Caregiver Assessment (if applicable). (Refer to Caregiver Assessment Procedures.)
- obtain the RUGs score, ADL Index score, and corresponding SHARe budget allocation to see if different from previous MDS-HC assessment.
- review the triggered CAPs and/or concerns identified on the reassessment to see if different from previous CAPs and/or concerns.
- determine if the individual continues to meet nursing facility level of care (Refer to Level of Care Manual).

- If the individual does NOT continue to meet nursing facility level of care, the SC will complete a narrative (including sufficient documentation to substantiate that the individual does not meet LOC) and complete CMIS Closure form and fax to R.O.

R.O. will:

- Review and verify that the individual does not continue to meet LOC.
- Send out a denial notice to the individual with appeal rights (including proposed termination in services notice) and a copy to the SCA.
  - If the individual appeals the decision, refer to the Appeals Procedures.

After the 30 days for appeal rights have passed AND the individual did NOT appeal, R.O. will notify the SC to complete a 148-W (Refer to 148-W Procedures) and complete CMIS Closure form (including sufficient documentation to substantiate that LOC was not met) and fax to R.O.

**NOTE: SC should NOT send a copy of the 148-W to the local Medicaid office.**

R.O. will process the 148-W to close the case and will email/scan a copy to Data Management Contractor, local Medicaid office and the SCA.

The SC will:

- close the case in CMIS.
- notify the provider(s) by speaking to a representative and by fax on the same date that 148-W is received from R.O.

If it appears that the individual continues to meet LOC, the SC will proceed with developing a new POC with the participant (Refer to Plan of Care Development Meetings Section).

## ***1.5 PLAN OF CARE (POC) DEVELOPMENT MEETINGS***

### **1.5.1 INITIAL POC DEVELOPMENT FOR INDIVIDUALS RESIDING IN THE COMMUNITY**

The SC will:

- schedule a face-to-face plan of care (POC) meeting with the participant and members of his/her support network. The planning team may include anyone requested by the participant, but at a minimum will include the individual, his/her responsible representative (if applicable) and the support coordinator.
- identify any potential risk factors (Refer to CCW Risk Assessment & Referral Screening Tool) and make appropriate referrals (Refer to CCW Referral Form).
- develop the Plan of Care (POC) using person-centered planning principles in identifying the services needed/already receiving.

**NOTE: If the SC determines that a Provisional POC is needed, refer to Provisional POC Section.**

- offer Freedom of Choice of providers. (Print current/appropriate list(s) from Provider Locator Tool (PLT).)
- encourage the participant to contact and interview providers, in order to make informed choice.
- complete the Emergency Plan.
- Fax copies of the following information (Demographic POC page; Emergency Plan; Signed FOC; & Flexible Schedule) to the chosen provider(s) for determination of whether or not the provider(s) can meet the individual's needs.
- obtain the Back-Up Staffing Plan from the provider.

**NOTE: If the provider cannot meet the individual's needs, the provider must submit to the SCA "good cause" reasons. If the SC determines that the provider does NOT have justifiable "good cause", the SC will notify provider for resolution prior to reporting to Health Standards Section. If it is determined the provider has justifiable "good cause", the SC must re-offer FOC of providers.**

The POC will:

- identify essential waiver services needed;
- identify services that are needed to further assess the participant;
- identify the funding source for the services [with the assistance of the identified professional (OT, PT, ATP, MT, etc.)]
- address all necessary CAPs;
- correlate with the MDS-HC Assessment;
- be outcome-oriented, individualized and time limited;
- be tailored to the participant's needs based on the on-going use of participant-focused assessment utilizing the Minimum Data Set – Home Care (MDS-HC);
- include strategies that will achieve or maintain desired personal outcomes.
- not be completed prior to the POC meeting;
- be written in language that is understandable to all parties involved; and
- contain all required signatures.

The SC will:

- Submit the completed entire POC packet (MDS-HC, POC, CAPs, Flexible Schedule, Budget Worksheet, Back-Up Staffing Plan, FOC pages, Responsible Representative form (if applicable), Caregiver Assessment (if applicable), Physician Delegation (if applicable), 148-W, & Emergency Plan) to the SC Supervisor for review and approval.

If the SC Supervisor determines it is not approvable, the entire packet will be returned to the SC to make appropriate corrections.

### **1.5.1.1 SC SUPERVISOR REVIEW PROCESS**

SC Supervisor will:

- review entire POC packet to be sure all documentation is included:
  - 148-W (Refer to 148-W Procedures);
  - Responsible Representative form (if applicable);
  - FOCs for all services;
  - All POC pages;
  - CAPs;
  - Budget Worksheet;
  - Flexible Schedule (with Provider agreement signed and dated at the bottom of schedule);

- Emergency Plan;
  - Caregiver Assessment (if applicable);
  - Physician Delegation (if applicable); and
  - Back-Up Staffing Plan (for PAS only).
- review all POC Packet pages to ensure they contain the necessary signatures and dates from individual, responsible representative, and/or provider(s) (Refer to POC Quality Review Tool).
  - review MDS-HC assessment for accuracy and ensures individual meets Pathways (Refer to LOC Quality Review Tool).

**NOTE: If individual meets NF level of care on Degree of Difficulty Questions (DDQs) or triggers Physician Involvement Pathway, Treatments and Conditions Pathway, Skilled Rehabilitation Therapies Pathway or Service Dependency Pathway, the SC Supervisor must look for appropriate documentation in MDS-HC notebook.**

- review the budget worksheet and flexible schedule to be sure budgeted amount is within the allotment given for the individual's RUG score for the CCW program.

**NOTE: If the SC Supervisor thinks that the individual is at risk of entering a NF and MAY need more supports, refer to SHARE Exceptions Procedures.**

**If individual's assessment shows him/her at Top of RUG Category AND has an ADL Index Score of 14 or 15, the SC Supervisor must conduct a home visit before submitting to R.O. for review.**

- review POC and CAPs to ensure they are appropriate for the individual and correlate with the MDS-HC assessment.
- review budget worksheet to ensure all provider names and numbers are entered correctly, as well as # of units and total cost.
- review flexible schedule to ensure it reflects the appropriate number of hours for the participant, and the weekly total/units are correct.

If any inconsistencies or concerns are found, SC Supervisor will address with the SC, and send POC packet back to SC for corrections, depending on the quantity of corrections. Once all corrections have been made, the SC Supervisor will proceed with approving the POC packet.

- complete the Plan of Care Action Section with the following:
  - “Date POC Approved”: Enter the actual date that the SC Supervisor approves the POC.
  - “MDS-HC Assessment Date”: Enter the actual date of MDS-HC Assessment.
- sign & date the budget worksheet and flexible schedule.
- complete the 142 (Refer to 142 Procedures.)
- fax the 142 to local Medicaid office.

**NOTE: The SC Supervisor must approve the POC and submit the 142 to local Medicaid office within thirty five (35) calendar days of notification of linkage.**

Once the Decision Notice (Approval) is received from Medicaid, SC Supervisor will:

- complete Section III. D of 142;
- complete Plan of Care Action Section with the following:
  - “POC Begin Date”: Enter the same date as the “Effective Date” on 142.
  - “POC End Date”: Enter the actual day before the POC Begin Date for the following year. (Example: POC Begin Date: 8/25/11 & POC End Date: 8/24/11)
  - “Date POC Packet Mailed to Individual”: Enter the date that the SC will mail the POC to the participant.
- complete appropriate boxes on “Notice of Approval” Section on POC.

Once all pages are completed, the SC Supervisor will:

- fax the following documents to the Data Management Contractor:
  - Decision Notice;

- 148-W;
  - 142;
  - POC Demographic Page;
  - POC Signature Page;
  - Budget Worksheet; and
  - Flexible Schedule.
- If problems are identified by the Data Management Contractor, a problem sheet will be sent directly to the SC Agency with a copy to R.O. (Refer to Data Management Contractor Problem Sheet Procedures)
- fax a copy of entire POC Packet to R.O.

On the day that the SC Supervisor approves the POC, the SC will:

- mail the participant copies of the following documents:
  - entire POC;
  - MDS-HC assessment; and
  - Emergency Plan.
- fax the provider(s) copies of the following documents:
  - entire POC (NOT including the Budget Worksheet);
  - 142;
  - Emergency Plan; and
  - Back-Up Staffing Plan.

The SC will:

- contact the participant and the provider(s) within three (3) calendar days to notify him/her of approval.
- contact the participant within ten (10) calendar days from the date of provider service initiation to assure the appropriateness and adequacy of the service delivery.

### **1.5.2 INITIAL POC DEVELOPMENT FOR INDIVIDUALS RESIDING IN THE NURSING FACILITY**

The SC will:

- schedule a face-to-face plan of care (POC) meeting with the individual and members of his/her support network. The planning team may include anyone requested by the individual, but at a minimum will include the individual, his/her responsible representative (if applicable) and the support coordinator. Other planning team members may include NF staff, Transition Coordinator (if individual selected My Place LA), ombudsmen, and/or other appropriate professionals.
- identify any potential risk factors (Refer to CCW Risk Assessment & Referral Screening Tool) and make appropriate referrals (Refer to CCW Referral Form).
- assist the individual with locating housing (if applicable), including assisting with gathering, locating, and obtaining all necessary documents needed for the housing application.
- identify the individual's community physician(s).
- determine if transition services are needed (what is needed to get out of the NF) (If applicable).
- determine a preliminary/projected move date.
- develop the Plan of Care (POC) using person-centered planning principles in identifying the services needed/already receiving.

**NOTE: If the SC determines that a Provisional POC is needed, refer to Provisional POC Section.**

- offer Freedom of Choice of providers. (Print current/appropriate list(s) from Provider Locator Tool (PLT).)
- encourage the participant to contact and interview providers, in order to make informed choice.
- complete the Emergency Plan.
- Fax copies of the following information (Demographic POC page; Emergency Plan; Signed FOC; & Flexible Schedule) to the chosen provider(s) for determination of whether or not the provider(s) can meet the individual's needs.
- obtain the Back-Up Staffing Plan from the provider.

**NOTE: If the provider cannot meet the individual's needs, the provider must submit to the SCA "good cause" reasons. If the SC determines that the provider does NOT have justifiable "good cause", the SC will notify provider for resolution prior to reporting to Health Standards Section. If it is determined the provider has justifiable "good cause", the SC must re-offer FOC of providers.**

The POC will:

- identify all needs/services (including Transition Services, if applicable) that allow the individual to transition out of the NF and also what the individual needs in the 1<sup>st</sup> couple of days/weeks in the community (including services that are needed to further assess the participant);
- identify the funding source for the services [with the assistance of the identified professional (OT, PT, MT, ATP, etc.)]
- identify unpaid natural supports that assists the individual;
- identify a preliminary/projected move date;
- include a transition plan that details what the individual has/needs as he/she transitions into the community, including housing;
- include TISC service in the Supports and Services section and on the budget sheet reflecting the estimated cost;
- address all necessary CAPs;
- correlate with the MDS-HC Assessment;
- be outcome-oriented, individualized and time limited;
- be tailored to the participant's needs based on the on-going use of participant-focused assessment utilizing the Minimum Data Set – Home Care (MDS-HC);
- include strategies that will achieve or maintain desired personal outcomes.
- not be completed prior to the POC meeting;
- be written in language that is understandable to all parties involved; and
- contain all required signatures.

The SC will:

- Conduct at least a monthly face-to-face visit with the individual at the NF to ensure that transition efforts are ongoing and that any barriers are properly addressed.
- Visit the prospective residence prior to the individual transitioning from the nursing facility.

- Submit the completed POC packet (MDS-HC, POC, CAPs, Flexible Schedule, Budget Worksheet, FOC pages, Back-Up Staffing Plan, Responsible Representative form (if applicable), 148-W, Physician Delegation (if applicable); Caregiver Assessment (if applicable), & Emergency Plan) to the SC Supervisor for review and approval.

If the SC Supervisor determines it is not approvable, the entire packet will be returned to the SC to make appropriate corrections.

### 1.5.2.1 SC SUPERVISOR REVIEW PROCESS

The SC Supervisor will:

- review entire POC packet to be sure all documentation is included:
  - 148-W (Refer to 148-W Procedures);
  - Responsible Representative form, if applicable;
  - FOCs for all services;
  - All POC pages;
  - CAPs;
  - Budget Worksheet;
  - Flexible Schedule (with Provider agreement signed and dated at the bottom of schedule);
  - Emergency Plan;
  - Caregiver Assessment (if applicable);
  - Physician Delegation (if applicable); and
  - Back-Up Staffing Plan (for PAS only).
- review all POC Packet pages to ensure they contain the necessary signatures and dates from individual, responsible representative, and/or provider(s) (Refer to POC Quality Review Tool).
- review MDS-HC assessment for accuracy (Refer to LOC Quality Review Tool).
- ensure that the following statement was included in the MDS-HC notebook: “Deemed to meet NF LOC eligibility due to current NF resident status.”, for those individuals transitioning from a NF that did **NOT** meet any Pathways.
- review the budget worksheet and flexible schedule to be sure budgeted amount is within the allotment given for the individual’s RUG score for the CCW program.

**NOTE: If the SC Supervisor thinks that the individual MAY need additional supports and may meet SHARe Exception Criteria, refer to SHARe Exceptions Procedures.**

**If individual's assessment shows him/her at Top of RUG Category AND has an ADL Index Score of 14 or 15, the SC Supervisor must conduct a home visit before submitting to R.O. for review.**

- review POC and CAPs to ensure they are appropriate for the individual and correlate with the MDS-HC assessment.
- review budget worksheet to ensure all provider names and numbers are entered correctly, as well as # of units and total cost.
- review flexible schedule to ensure it reflects the appropriate number of hours for the participant, and the weekly total/units are correct.
- conduct a home visit at the individual's perspective residence.

If any inconsistencies or concerns are found, SC Supervisor will address with the SC, and sends POC packet back to SC for corrections. Once all corrections are made, the SC Supervisor will proceed with approving the POC packet.

- complete the Plan of Care Action Section with the following:
  - "Date POC Approved": Enter the actual date that the SC Supervisor approves the POC.
  - "MDS-HC Assessment Date": Enter the actual date of the MDS-HC Assessment.
- sign & date the budget worksheet and flexible schedule.
- complete the 142 (Refer to 142 Procedures.)
- fax the 142 to local Medicaid office.

**NOTE: The SC Supervisor must approve the POC and submit the 142 to local Medicaid office within thirty five (35) calendar days of notification of linkage.**

Once the Decision Notice (Approval) is received from Medicaid, SC Supervisor will:

- complete Section III. D of 142;

- complete Plan of Care Action Section with the following:
  - "Currently in NF": Check appropriate box – Yes or No (if applicable).
  - "Date Transitioned from NF to Community": Enter the actual date that the individual transitioned from the NF to his/her home (if applicable).  
"POC Begin Date": Enter the day after the POC End Date of the Provisional POC.
  - "POC Begin Date": Enter the same date as the "Effective Date" on 142.
  - "POC End Date": Enter the actual day before the POC Begin Date for the following year. (Example: POC Begin Date: 8/25/11 & POC End Date: 8/24/11)
  - "Date POC Packet Mailed to Individual": Enter the date that the SC will mail the POC to the participant.
- complete remaining boxes on "Notice of Approval" Section on POC.

Once all pages are completed, the SC Supervisor will:

- fax the following documents to the Data Management Contractor:
  - Decision Notice;
  - 148-W;
  - 142;
  - POC Demographic Page;
  - POC Signature Page;
  - Budget Worksheet; and
  - Flexible Schedule.
- If problems are identified by the Data Management Contractor, a problem sheet will be sent directly to the SC Agency with a copy to R.O. (Refer to Data Management Contractor Problem Sheet Procedures)
- fax a copy of entire POC Packet to R.O.

On the day that the SC Supervisor approves the POC, the SC will:

- mail the participant copies of the following documents:
  - entire POC;
  - MDS-HC assessment; and
  - Emergency Plan.
- fax the provider(s) copies of the following documents:
  - entire POC (Not including the Budget Worksheet);
  - 142;
  - Emergency Plan; and
  - Back-Up Staffing Plan.

The SC will:

- contact the participant and the provider(s) within three (3) calendar days to notify him/her of approval.
- contact the participant within ten (10) calendar days from the date of provider service initiation to assure the appropriateness and adequacy of the service delivery as reflected on the POC.

Closer to the date of the participant transitioning out of the NF, the SC will:

- Request individual's personal funds from the NF and open a personal bank account for the individual, if he/she wishes;
- Make a list of all personal belongings to be transferred with the individual;
- Assist the individual in changing the representative payee and/or address change for Social Security/Supplemental Security Income (SSI) and/or other benefits, if applicable.

**NOTE: It is very important that the individual contact the local Social Security Administration office on the actual day of the move to avoid any delay in benefits.**

- Arrange for DSP staff coverage, transportation for the individual on the date of discharge from the NF, and for transportation of the individual's personal belongings.

- Assist with assuring that all transition service expenses identified on the Transition Services Expense and Planning and Approval (TSEPA) form have been purchased and set-up in the individual's residence (if applicable).

On the day of transition into the community, the SC Supervisor will:

- complete the 148-W indicating transition date from the NF (Refer to 148-W Procedures) and fax to the local Medicaid Office, Data Management Contractor and MFP (if applicable).

On the day of transition into the community, the SC will:

- Conduct a face-to-face visit with the individual at his/her new residence to ensure that identified needs/services are in place;

The SC will complete a POC Revision indicating date of transition into the community and identifying the needs of the participant now that he/she is out of the NF (Refer to POC Revisions: Routine Procedures).

### **1.5.3 PROVISIONAL PLANS OF CARE (POCs)**

An initial Provisional Plan of Care (POC) may be developed by the SC.

The Provisional POC:

- will allow some services to get started quickly pending completion of a more in-depth assessment and/or a more comprehensive Plan of Care.
- are optional but in some cases are beneficial to the participant.
- should be used ONLY when it makes sense to do so.
- may be helpful when a service needs to be started to facilitate the initial assessment and Plan of Care process itself.

**Examples:**

A participant with a history of falls may benefit from a nursing, occupational therapy (OT) or physical therapy (PT) assessment as part of the comprehensive Plan of Care process. In order for a participant to receive such an assessment, a SC must submit a Provisional POC authorizing a nursing or PT/OT assessment. Once that professional assessment is completed, the SC would use that assessment and its recommendations in completing the Comprehensive POC and CAPs. Used in this way, Provisional POCs allow SCs to take a more inter-disciplinary approach to planning.

Provisional POC may be used when services need prior approval. For instance, under the Community Choices Waiver, environmental accessibility adaptations (EAA) require an EAA assessment to determine whether the adaptation is appropriate and necessary; and whether the individual's needs could better, or as effectively, be met through assistive devices. A SC should use the Provisional POC to authorize the EAA assessment prior to completing the Comprehensive POC.

Provisional POC may also be used in nursing facility transition cases where it is clear that an individual is in urgent need of one or more services but it is difficult to determine the best comprehensive approach and more time is needed for assessment and planning.

There are some special conditions that apply when using Provisional POCs, and SCs should bear these in mind before choosing to do a Provisional POC. In many instances, it may be more appropriate to complete an Initial POC on these cases and make revisions after the Initial POC is implemented.

Provisional POCs will:

- be completed after the Minimum Data Set-Home Care (MDS-HC) is conducted with the applicant.
- be completed on initial Community Choices Waiver (CCW) cases only.
- identify the essential Medicaid services that shall be provided in the participant's first sixty (60) days of waiver eligibility.

The SC will:

- offer Freedom of Choice of providers. (Print current/appropriate list(s) from Provider Locator Tool (PLT).)
- encourage the participant to contact and interview providers, in order to make informed choice.

- develop the Provisional POC using person-centered planning principles in identifying the services needed/already receiving.

**NOTE: If NF Transition case, the Provisional POC should only include the services that will be provided before the person transitions out of the NF.**

- complete the Emergency Plan (if applicable).
- Fax copies of the following information (Demographic POC page; Emergency Plan (if applicable); Signed FOC; & Flexible Schedule) to the chosen provider(s) for determination of whether or not the provider(s) can meet the individual's needs.
- fax CCW Referral form to the chosen provider(s) for assessment/recommendation (if applicable).
- obtain the Back-Up Staffing Plan from the provider. (if applicable)

**NOTE: If the provider cannot meet the individual's needs, the provider must submit to the SCA "good cause" reasons. If the SC determines that the provider does NOT have justifiable "good cause", the SC will notify provider for resolution prior to reporting to Health Standards Section. If it is determined the provider has justifiable "good cause", the SC must re-offer FOC of providers.**

The Provisional POC will:

- Identify essential waiver services needed prior to the completion of the Comprehensive Plan of Care (POC).
- Identify services that are needed to further assess the participant.
- Identify the funding source for the services [with the assistance of the identified professional (OT, PT, MT, ATP, etc.)].
- (For NF Transitions ONLY): Identify basic transitional services needed for a smooth transition into the community during the first 60 days such as living arrangement, essential furnishings for basic living, food, utilities, deposits, medications, a means for contacting emergency services, and physician referral to a home health agency for an immediate nursing assessment.
- be time limited;
- be tailored to the participant's needs based on the Minimum Data Set – Home Care (MDS-HC);
- not be completed prior to the POC meeting;
- be written in language that is understandable to all parties involved; and
- contain all required signatures.

**NOTE: SCs DO NOT need to plan for EVERY CAP that is triggered on the MDS-HC assessment. The provisional POC needs to make sure that enough information is included to explain why the services being authorized are essential and /or necessary to complete the comprehensive POC.**

The SC will:

- Submit the completed applicable pages of the Provisional POC packet (MDS-HC, POC, CAPs, Flexible Schedule, Budget Worksheet, FOC pages, Back-Up Staffing Plan Responsible Representative form (if applicable), Caregiver Assessment (if applicable); Physician Delegation (if applicable) & Emergency Plan) to the SC Supervisor for review and approval.

If the SC Supervisor determines it is not approvable, the entire packet will be returned to the SC to make appropriate corrections.

### **1.5.3.1 SC SUPERVISOR REVIEW PROCESS**

SC Supervisor will:

- review applicable Provisional POC packet pages to be sure all documentation is included:
  - 148-W (Refer to 148-W Procedures);
  - Responsible Representative form, if applicable;
  - FOCs for all services identified;
  - All POC pages;
  - CAPs;
  - Budget Worksheet;
  - Flexible Schedule (with Provider agreement signed and dated at the bottom of schedule;
  - Caregiver Assessment (if applicable);
  - Physician Delegation (if applicable);
  - Emergency Plan (if applicable); and
  - Back-Up Staffing Plan (for PAS only) – if applicable.
- review all Provisional POC Packet pages to ensure they contain the necessary signatures and dates from individual, responsible representative, and/or provider(s) (Refer to POC Quality Review Tool).
- review MDS-HC assessment for accuracy and ensures individual meets Pathways (Refer to LOC Quality Review Tool).

**NOTE: For those individuals transitioning from a NF that did NOT meet any Pathways, the SC Supervisor must ensure that the following statement was included in the MDS-HC notebook: “Deemed to meet NF LOC eligibility due to current NF resident status.”**

- review the budget worksheet and flexible schedule to be sure budgeted amount is within the allotment given for the individual’s RUG score for the CCW program.

**NOTE: If the SC Supervisor thinks that the individual is at risk of entering a NF and MAY need more supports, refer to SHARE Exceptions Procedures.**

**If individual’s assessment shows him/her at Top of RUG Category AND has an ADL Index Score of 14 or 15, the SC Supervisor must conduct a home visit before submitting to R.O. for review.**

- review POC and CAPs to ensure they are appropriate for the individual and correlate with the MDS-HC assessment.
- review budget worksheet to ensure all provider names and numbers are entered correctly, as well as # of units and total cost.
- review flexible schedule to ensure it reflects the appropriate number of hours for the participant, and the weekly total/units are correct.

If any inconsistencies or concerns are found, SC Supervisor will address with the SC, and send POC packet back to SC for corrections, depending on the quantity of corrections. Once all corrections have been made, the SC Supervisor will proceed with approving the POC packet.

- complete the Plan of Care Action Section with the following:
  - “Date POC Approved”: Enter the actual date that the SC Supervisor approves the POC.
  - “MDS-HC Assessment Date”: Enter the actual date of the MDS-HC Assessment.
- sign & date the budget worksheet and flexible schedule.
- complete the 142 (Refer to 142 Procedures.)
- fax the 142 to local Medicaid office.

**NOTE: The SC Supervisor must approve the POC and submit the 142 to local Medicaid office within fifteen (15) calendar days of notification of linkage.**

On the day that the Decision Notice (Approval) is received from Medicaid, the SC Supervisor will:

- complete Section III. D of 142;
- complete Plan of Care Action Section with the following:
  - "Currently in NF": Check appropriate box – Yes or No (if applicable).
  - "Date Transitioned from NF to Community": Enter the actual date that the individual transitioned from the NF to his/her home (if applicable).
  - "POC Begin Date": Enter the day after the POC End Date of the Provisional POC.
  - "POC End Date": Enter sixty (60) days from the POC Begin Date.  
(Example: POC Begin Date: 9/01/11 & POC End Date: 10/30/11)
  - "Date POC Packet Mailed to Individual": Enter the date that the SC will mail the POC to the participant.
- sign & date the budget worksheet and flexible schedule.
- complete appropriate boxes on "Notice of Approval" Section on POC.

Once all pages are completed, the SC Supervisor will:

- fax the following documents to the Data Management Contractor:
  - Decision Notice;
  - 148-W;
  - 142;
  - POC Demographic Page;
  - POC Signature Page;
  - Budget Worksheet; and
  - Flexible Schedule.

- If problems are identified by the Data Management Contractor, a problem sheet will be sent directly to the SC Agency with a copy to R.O. (Refer to Data Management Contractor Problem Sheet Procedures)
- fax a copy of entire Provisional POC Packet to R.O.

On the day that the SC Supervisor approves the Provisional POC, the SC will:

- mail the participant copies of the following documents:
  - entire POC;
  - MDS-HC assessment; and
  - Emergency Plan (if applicable).
- fax the provider(s) copies of the following documents:
  - entire POC (Not including the Budget Worksheet);
  - 142;
  - Emergency Plan (if applicable); and
  - Back-Up Staffing Plan (if applicable).

The SC will:

- contact the participant and the provider(s) within three (3) calendar days to notify him/her of approval.
- contact the participant within ten (10) calendar days from the date of provider service initiation to assure the appropriateness and adequacy of the service delivery.

#### 1.5.4 COMPREHENSIVE PLANS OF CARE (POCs)

Comprehensive Plans of Care (POCs) will **only** be completed by the SC if the SC initially completed a Provisional POC with the participant.

The SC will:

- offer Freedom of Choice of providers. (Print current/appropriate list(s) from Provider Locator Tool (PLT).)
- encourage the participant to contact and interview providers, in order to make informed choice.

- develop the Comprehensive POC using person-centered planning principles in identifying the services needed/already receiving.

**NOTE: Provider(s) are not required to be at the POC meeting(s), UNLESS the participant requests the provider(s) to be present at the meeting.**

- complete the Emergency Plan (if applicable).
- Fax copies of the following information (Demographic POC page; Emergency Plan (if applicable); Signed FOC; & Flexible Schedule) to the chosen provider(s) for determination of whether or not the provider(s) can meet the individual's needs.
- fax CCW Referral form to the chosen provider(s) for assessment/recommendation (if applicable).
- obtain the Back-Up Staffing Plan from the provider. (if applicable)

**NOTE: If the provider cannot meet the individual's needs, the provider must submit to the SCA "good cause" reasons. If the SC determines that the provider does NOT have justifiable "good cause", the SC will notify provider for resolution prior to reporting to Health Standards Section. If it is determined the provider has justifiable "good cause", the SC must re-offer FOC of providers.**

The Comprehensive POC will:

- identify essential waiver services;
- address all necessary CAPs;
- correlate with the MDS-HC Assessment;
- be outcome-oriented, individualized and time limited;
- be tailored to the participant's needs based on the on-going use of participant-focused assessment utilizing the Minimum Data Set – Home Care (MDS-HC);
- include strategies that will achieve or maintain desired personal outcomes;
- be written in language that is understandable to all parties involved; and
- contain all required signatures.

If Nursing Facility Transition, the Comprehensive POC will also:

- identify all needs/services (including Transition Services, if applicable) that allow the individual to transition out of the NF and also what the individual needs in the 1<sup>st</sup> couple of days/weeks in the community;
- identify unpaid natural supports that assists the individual;

- identify a preliminary/projected move date;
- include a transition plan that details what the individual has/needs as he/she transitions into the community, including housing; and
- include TISC service in the Supports and Services section on the POC and on the budget worksheet reflecting the estimated cost.

The SC will:

- Submit the completed applicable pages of the Comprehensive POC packet (MDS-HC, POC, CAPs, Flexible Schedule, Budget Worksheet, FOC pages, Back-Up Staffing Plan, Responsible Representative form (if applicable), 148-W (if applicable) Caregiver Assessment (if applicable); Physician Delegation (if applicable), & Emergency Plan) to the SC Supervisor for review and approval.

If the SC Supervisor determines it is not approvable, the entire Comprehensive POC packet will be returned to the SC to make appropriate corrections.

#### **1.5.4.1 SC SUPERVISOR REVIEW PROCESS**

SC Supervisor will:

- review applicable Comprehensive POC packet pages to be sure all documentation is included:
  - 148-W (if applicable - Refer to 148-W Procedures);
  - Responsible Representative form (if applicable);
  - FOCs for all services identified;
  - All POC pages;
  - CAPs;
  - Budget Worksheet;
  - Flexible Schedule (with Provider agreement signed and dated at the bottom of schedule);
  - Caregiver Assessment (if applicable);
  - Physician Delegation (if applicable);
  - Emergency Plan (if applicable); and
  - Back-Up Staffing Plan (for PAS only) – if applicable.
- review all Comprehensive POC Packet pages to ensure they contain the necessary signatures and dates from individual, responsible representative, and/or provider(s) (Refer to POC Quality Review Tool).

- review MDS-HC assessment for accuracy and ensures individual meets Pathways (Refer to LOC Quality Review Tool).

**NOTE: For those individuals transitioning from a NF that did NOT meet any Pathways, the SC Supervisor must ensure that the following statement was included in the MDS-HC notebook: “Deemed to meet NF LOC eligibility due to current NF resident status.”**

- review the budget worksheet and flexible schedule to be sure budgeted amount is within the allotment given for the individual’s RUG score for the CCW program.

**NOTE: If the SC Supervisor thinks that the individual is at risk of entering a NF and MAY need more supports, refer to SHARe Exceptions Procedures.**

- review POC and CAPs to ensure they are appropriate for the individual and correlate with the MDS-HC assessment.
- review budget worksheet to ensure all provider names and numbers are entered correctly, as well as # of units and total cost.
- review flexible schedule to ensure it reflects the appropriate number of hours for the participant, and the weekly total/units are correct.

If any inconsistencies or concerns are found, SC Supervisor will address with the SC, and send POC packet back to SC for corrections, depending on the quantity of corrections. Once all corrections have been made, the SC Supervisor will proceed with approving the POC packet.

- complete the Plan of Care Action Section with the following:
  - “Date POC Approved”: Enter the actual date that the SC Supervisor approves the POC.
  - "Currently in NF": Check appropriate box – Yes or No (if applicable).
  - “Date Transitioned from NF to Community”: Enter the actual date that the individual transitioned from the NF to his/her home (if applicable).
  - “POC Begin Date”: Enter the day after the POC End Date of the Provisional POC.
  - “POC End Date”: Enter the actual day before the POC Begin Date

(of the Provisional POC) for the following year. (Example: Provisional POC End Date was 8/24/11, so the Comprehensive POC Begin Date: 8/25/11 & Comprehensive POC End Date: 8/24/11)

- “Date POC Packet mailed to individual”: Enter the date that the SC will mail the POC to the participant.
- sign & date the budget worksheet and flexible schedule.
- complete remaining appropriate boxes on “Notice of Approval” Section on POC.

Once all pages are completed, the SC Supervisor will:

- fax the following documents to the Data Management Contractor no later than fourteen (14) days prior to the POC Expiration Date on the Provisional POC:
  - Decision Notice;
  - 148-W;
  - 142;
  - POC Demographic Page;
  - POC Signature Page;
  - Budget Worksheet; and
  - Flexible Schedule.

**NOTE: SCA will not be reimbursed for services provided on a Provisional POC that exceeds sixty (60) days AND the SCA will be held responsible for any federal disallowance for services delivered by provider(s) on an expired Provisional POC.**

- If problems are identified by the Data Management Contractor, a problem sheet will be sent directly to the SC Agency with a copy to R.O. (Refer to Data Management Contractor Problem Sheet Procedures)
- fax a copy of entire Comprehensive POC Packet to R.O.

Once the SC Supervisor approves the Comprehensive POC, the SC will:

- send the participant copies of the following documents:
  - entire POC; and
  - Emergency Plan (if applicable).
- contact the participant and the provider(s) within three (3) calendar days to notify him/her of approval.

- contact the participant within ten (10) calendar days from the date of provider service initiation to assure the appropriateness and adequacy of the service delivery.
- send the provider(s) copies of the following documents:
  - entire POC (Not including the Budget Worksheet);
  - Emergency Plan (if applicable); and
  - Back-Up Staffing Plan (if applicable).

## 1.5.5 POC REVISIONS

### 1.5.5.1 ROUTINE

The following are some examples for Routine POC Revisions:

- Provider Change for upcoming quarter;
- Service Change (hour increase/decrease, add PERS, add/referral for Skilled Maintenance Therapies, etc.);
- Environmental Accessibility Adaptation (EAA);
- Participant leaving a Nursing Facility (A POC Revision is necessary once the individual transitions home to identify additional needs/services.)

### 1.5.5.2 EMERGENCY

The following are some examples for Emergency POC Revisions:

- Provider Change that needs to occur immediately with good cause.
  - Conflict between participant and provider;
  - Provider continuously not providing back-up staff; etc.

The SC will:

- compile all necessary paperwork for the POC Revision.

- identify any potential factors (Refer to CCW Risk Assessment & Referral Screening Tool) and make appropriate referrals (Refer to CCW Referral Form). (if applicable)
- offer Freedom of Choice of providers. (Print current/appropriate list(s) from Provider Locator Tool (PLT).) (if applicable)
- encourage the participant to contact and interview providers, in order to make informed choice. (if applicable)
- complete the POC Revision.

**NOTE: Provider(s) are not required to be at the POC Revision meeting(s), UNLESS the participant requests the provider(s) to be present at the meeting.**

- complete the Emergency Plan (if applicable).
- fax copies of the following information (Demographic POC page; Emergency Plan (if applicable); Signed FOC (if applicable); & Flexible Schedule) to the chosen provider(s) for determination of whether or not the provider(s) can meet the individual's needs.
- obtain the Back-Up Staffing Plan from the provider. (if applicable)

**NOTE: If the provider cannot meet the individual's needs, the provider must submit to the SCA "good cause" reasons. If the SC determines that the provider does NOT have justifiable "good cause", the SC will notify provider for resolution prior to reporting to Health Standards Section. If it is determined the provider has justifiable "good cause", the SC must re-offer FOC of providers. (if applicable)**

- complete the POC Revision and include reason for the revision on Page 1 of the POC.

**NOTE: For NF Transition, POC Revisions need to indicate the date that the participant transitioned into the community on Plan of Care Action Section of the POC.**

- send the entire POC Revision packet to SC Supervisor.

### **1.5.5.2.1 SC SUPERVISOR REVIEW PROCESS**

SC Supervisor will:

- review entire POC Revision packet to be sure all documentation is included:
  - All applicable POC pages;
  - Budget Worksheet;
  - Flexible Schedule;
  - Emergency Plan (if applicable);
  - Caregiver Assessment (if applicable);
  - Physician Delegation (if applicable);
  - Responsible Representative form (if applicable); and
  - Signed FOC forms (if applicable).
- review POC Revision Packet to ensure they contain the necessary signatures and dates from individual, responsible representative, and/or provider(s) (Refer to POC Quality Review Tool).
- review budget worksheet to ensure all provider names and numbers are entered correctly, as well as # of units and total cost.
- review flexible schedule to ensure it reflects the appropriate number of hours for the participant and the weekly total/units are correct.

**NOTE: If the SC Supervisor thinks that the participant is at risk of entering a NF and MAY need additional supports, refer to SHARE Exceptions Procedures.**

**If the participant was previously approved under PAS Conversion, refer to Applying PAS Conversion Procedures.**

**If any inconsistencies or concerns are found, SC Supervisor will address with the SC, and sends POC packet back to SC for corrections. Once all corrections are received and approvable, the POC Revision will be approved by the SC Supervisor.**

Once the POC Revision Packet is approvable, the SC Supervisor will:

- complete Plan of Care Action Section on the POC with the following:
  - “Date POC Approved”: Enter the actual date that the SC Supervisor approves the POC Revision.

- “POC Revision Begin Date”: Enter the begin date appropriate for the POC Revision.
- “POC Revision End Date”: Enter the end date appropriate for the POC Revision.
- “Date POC Packet mailed to individual”: Enter the date that the SC will mail the POC Revision to the participant.
- sign & date the budget worksheet and flexible schedule.
- complete remaining appropriate boxes on “Notice of Approval” Section on POC (if applicable).
- **FOR REDUCTIONS ONLY:** complete Fair Hearing Rights and Reduction in Services Sections.

**NOTE: For Fair Hearing Rights, enter thirty (30) days from the date the entire POC is mailed to the participant.**

**For Reduction in Services, enter the actual date of the proposed reduction. The SC MUST mail the entire POC to the participant NO later than fourteen (14) days prior to the date of the proposed reduction.**

Once all pages are completed, the SC Supervisor will:

- fax the following documents to the Data Management Contractor:
  - POC Demographic Page;
  - POC Signature Page;
  - Budget Worksheet; and
  - Flexible Schedule.
- Routine POC Revisions are due within five (5) calendar days from the date of the reported change.

**NOTE: Unless a reassessment was conducted and indicates a change in the participant’s condition, then the Routine Plan of Care Revision is due fourteen (14) calendar days after the completion date of the reassessment.**

- Emergency POC Revisions are due within twenty-four (24) hours from the date of the reported change.

- If problems are identified by the Data Management Contractor, a problem sheet will be sent directly to the SC Agency with a copy to R.O. (Refer to Data Management Contractor Problem Sheet Procedures)
- fax a copy of entire POC Revision to R.O.

Once the SC Supervisor approves the POC Revision, the SC will:

- fax the provider(s) copies of the following documents:
  - entire POC Revision Pages (Not including the Budget Worksheet);
  - Emergency Plan (if applicable); and
  - Back-Up Staffing Plan (if applicable)
- mail the participant copies of the following documents:
  - entire POC;
  - MDS-HC reassessment; and
  - Emergency Plan (if applicable).

### 1.5.6 ANNUAL POCs

The SC will:

- schedule a face-to-face plan of care (POC) meeting with the participant and members of his/her support network. The planning team may include anyone requested by the participant, but at a minimum will include the individual, his/her responsible representative (if applicable) and the support coordinator.
- identify any potential risk factors (Refer to CCW Risk Assessment & Referral Screening Tool) and make appropriate referrals (Refer to CCW Referral Form).
- develop the Annual Plan of Care (POC) using person-centered planning principles in identifying the services needed/already receiving.
- offer Freedom of Choice of providers. (Print current/appropriate list(s) from Provider Locator Tool (PLT).)

**NOTE: Provider(s) are not required to be at the POC meeting(s), UNLESS the participant requests the provider(s) to be present at the meeting.**

- encourage the participant to contact and interview providers, in order to make informed choice.

- complete the Emergency Plan.
- fax copies of the following information (Demographic POC page; Emergency Plan; Signed FOC form(s); & Flexible Schedule) to the chosen provider(s) for determination of whether or not the provider(s) can meet the individual's needs.
- obtain the Back-Up Staffing Plan from the provider.

**NOTE: If the provider cannot meet the individual's needs, the provider must submit to the SCA "good cause" reasons. If the SC determines that the provider does NOT have justifiable "good cause", the SC will notify provider for resolution prior to reporting to Health Standards Section. If it is determined the provider has justifiable "good cause", the SC must re-offer FOC of providers.**

The Annual POC will:

- address all necessary CAPs;
- correlate with the MDS-HC Assessment;
- be outcome-oriented, individualized and time limited;
- be tailored to the participant's needs based on the on-going use of participant-focused assessment utilizing the Minimum Data Set – Home Care (MDS-HC);
- include strategies that will achieve or maintain desired personal outcomes.
- not be completed prior to the POC development meeting;
- be written in language that is understandable to all parties involved; and
- contain all required signatures.

The SC will:

- Submit the completed Annual POC packet (MDS-HC, POC, CAPs, Flexible Schedule, Budget Worksheet, Back-Up Staffing Plan, FOC pages (if applicable), Responsible Representative form (if applicable), Caregiver Assessment (if applicable), Physician Delegation (if applicable) & Emergency Plan) to the SC Supervisor for review and approval.

If the SC Supervisor determines it is not approvable, the entire packet will be returned to the SC to make appropriate corrections.

### 1.5.6.1 SC SUPERVISOR REVIEW PROCESS

SC Supervisor will:

- review entire Annual POC packet to be sure all documentation is included:
  - Responsible Representative form (if applicable);
  - FOCs for all services;
  - All POC pages;
  - CAPs;
  - Budget Worksheet;
  - Flexible Schedule (with Provider agreement signed and dated at the bottom of schedule);
  - Physician Delegation (if applicable);
  - Caregiver Assessment (if applicable);
  - Emergency Plan; and
  - Back-Up Staffing Plan (for PAS only).
- review all Annual POC Packet pages to ensure they contain the necessary signatures and dates from individual, responsible representative, and/or provider(s) (Refer to POC Quality Review Tool).
- review MDS-HC assessment for accuracy and ensures individual continues to meet Pathways (Refer to LOC Quality Review Tool).

**NOTE: If the participant meets NF level of care by triggering on the following Pathways: Physician Involvement, Treatments and Conditions, Skilled Rehabilitation Therapies or Service Dependency, the SC Supervisor must look for appropriate documentation in MDS-HC notebook.**

- review the budget worksheet and flexible schedule to be sure budgeted amount is within the allotment given for the participant's RUG score for the CCW program.

**NOTE: If the SC Supervisor thinks that the participant is at risk of entering a NF and MAY need additional supports, refer to SHARe Exceptions Procedures.**

**If the participant was previously approved under PAS Conversion, refer to Applying PAS Conversion Procedures.**

**If participant's assessment shows him/her at Top of RUG Category AND has an ADL Index Score of 14 or 15, the SC Supervisor must conduct a home visit before submitting to R.O. for review.**

- review POC and CAPs to ensure they are appropriate for the participant individual and correlate with the MDS-HC assessment.
- review budget worksheet to ensure all provider names and numbers are entered correctly, as well as # of units and total cost.
- review flexible schedule to ensure it reflects the appropriate number of hours for the participant and the weekly total/units are correct.

**NOTE: If any inconsistencies or concerns are found, SC Supervisor will address with the SC, and sends POC packet back to SC for corrections, depending on the quantity of corrections needed, as well as severity. Once all needed documentation (MDS-HC, Budget Worksheet, and Flexible Schedule) is received and are correct, appropriate and approvable, the Annual POC will be approved by the SC Supervisor.**

Once the Annual POC Packet is approvable, the SC Supervisor will:

- complete Plan of Care Action Section with the following:
  - “Date POC Approved”: Enter the actual date that the SC Supervisor approves the POC.
  - “MDS-HC Assessment Date”: Enter the actual date of the MDS-HC Reassessment.
  - “POC Begin Date”: Enter the actual day of the previous POC Begin Date, but for the following year (excluding POC Revisions).
  - “POC End Date”: Enter the actual day before the POC Begin Date for the following year. (Example: POC Begin Date: 8/25/11 & POC End Date: 8/24/11)
  - “Date POC Packet mailed to individual”: Enter the date that the SC will mail the POC Revision to the participant.
- sign & date the budget worksheet and flexible schedule.
- complete remaining appropriate boxes on “Notice of Approval” Section on POC.
- **FOR REDUCTIONS ONLY:** complete Fair Hearing Rights and Reduction in Services Sections.

**NOTE: For Fair Hearing Rights, enter thirty (30) days from the date the entire POC is mailed to the participant.**

**For Reduction in Services, enter the actual date of the proposed reduction. The SC MUST mail the entire POC to the participant NO later than fourteen (14) days prior to the date of the proposed reduction.**

Once all pages are completed, the SC Supervisor will:

- fax the following documents to the Data Management Contractor no later than fourteen (14) calendar days from the current POC Expiration Date:
  - POC Demographic Page;
  - POC Signature Page;
  - Budget Worksheet; and
  - Flexible Schedule.

**NOTE: POC Expiration Date is the day after the POC End Date.**

- If problems are identified by the Data Management Contractor, a problem sheet will be sent directly to the SC Agency with a copy to R.O. (Refer to Data Management Contractor Problem Sheet Procedures)
- fax a copy of entire Annual POC Packet to R.O. no later than fourteen (14) calendar days of POC Expiration Date.

Once the SC Supervisor approves the Annual POC, the SC will:

- mail the participant copies of the following documents:
  - entire POC;
  - MDS-HC assessment; and
  - Emergency Plan.
- fax the provider(s) the following documents:
  - entire POC (Not including Budget Worksheet);
  - Emergency Plan; and
  - Back-Up Staffing Plan
- contact the new provider(s) within three (3) calendar days to notify him/her of approval (if applicable).

- contact the participant within ten (10) calendar days from the date of the new provider service initiation to assure the appropriateness and adequacy of the new service delivery.

### 1.5.7 LATE POCs

If an Annual POC is submitted later than the required timeframe (14 calendar days from the current POC Expiration Date), the POC is considered late.

**NOTE: The ONLY valid reason for late Plans of Care (POCs) are when participants are temporarily admitted to a hospital, nursing facility or acute care facility.**

**POC Expiration Date is the day after the POC End Date.**

The SC will:

- compile all necessary paperwork for the POC Revision (Refer to POC Revision Sections).
- complete a POC Revision (Refer to POC Revision Sections) and include reason for the revision on Page 1 of the POC.
- send the entire POC Revision packet to SC Supervisor.

#### 1.5.7.1 SC SUPERVISOR REVIEW PROCESS

SC Supervisor will:

- review entire POC Revision packet to be sure all documentation is included:
  - All applicable POC pages;
  - Budget Worksheet; and
  - Flexible Schedule.
- review POC Revision Packet to ensure they contain the necessary signatures and dates from individual, responsible representative, and/or provider(s) (Refer to POC Quality Review Tool).

- review budget worksheet to ensure all provider names and numbers are entered correctly, as well as # of units and total cost.
- review flexible schedule to ensure it reflects the appropriate number of hours for the participant and the weekly total/units are correct.

**NOTE: If any inconsistencies or concerns are found, SC Supervisor will address with the SC, and sends POC packet back to SC for corrections. Once all corrections are received and approvable, the POC Revision will be approved by the SC Supervisor.**

Once the POC Revision Packet is approvable, the SC Supervisor will:

- complete Plan of Care Action Section with the following:
  - “Date POC Approved”: Enter the actual date that the SC Supervisor approves the POC Revision.
  - “POC Revision Begin Date”: Enter the day after the old (current) POC expired.
  - “POC Revision End Date”: Enter no more than thirty (30) calendar days from the POC Revision Begin Date. (Example: POC Revision Begin Date: 8/1/11 & POC Revision End Date: 8/30/11)
  - “Date POC Packet mailed to individual”: Enter the date that the SC will mail the POC Revision to the participant.
- sign & date the budget worksheet and flexible schedule.
- complete remaining appropriate boxes on “Notice of Approval” Section on POC (if applicable).
- **FOR REDUCTIONS ONLY:** complete Fair Hearing Rights and Reduction in Services Sections.

**NOTE: For Fair Hearing Rights, enter thirty (30) days from the date the entire POC is mailed to the participant.**

**For Reduction in Services, enter the actual date of the proposed reduction. The SC MUST mail the entire POC to the participant NO later than fourteen (14) days prior to the date of the proposed reduction.**

Once all pages are completed, the SC Supervisor will:

- fax the following documents to the Data Management Contractor:
  - POC Demographic Page;
  - POC Signature Page;
  - Budget Worksheet; and
  - Flexible Schedule.
- If problems are identified by the Data Management Contractor, a problem sheet will be sent directly to the SC Agency with a copy to R.O. (Refer to Data Management Contractor Problem Sheet Procedures)
- fax a copy of entire POC Revision to R.O.

Once the SC Supervisor approves the POC Revision, the SC will:

- mail the participant copies of the following documents:
  - entire POC Revision;
  - MDS-HC assessment (if applicable); and
  - Emergency Plan (if applicable).
- fax the provider(s) the following documents:
  - entire POC (Not including Budget Worksheet);
  - Emergency Plan (if applicable); and
  - Back-Up Staffing Plan (if applicable).
- contact the new provider(s) within three (3) calendar days to notify him/her of revision approval (if applicable).
- contact the participant within ten (10) calendar days from the date of the new provider service initiation to assure the appropriateness and adequacy of the new service delivery (if applicable).

**NOTE: The SCA will complete/resubmit a new POC Revision every thirty (30) calendar days to extend the POC until the SCA completes the Annual POC.**

**Once the participant leaves from the hospital, nursing facility or acute care facility, the SC is responsible for completing the entire Annual POC Process within sixty (60) calendar days from the date he/she transitions back home.**

## 2.0 CAREGIVER ASSESSMENTS PROCEDURES

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### 2.1 OVERVIEW

A Caregiver Assessment must be administered to:

- anyone who self-identifies as a family caregiver or is providing assistance with the individual's ADLs or IADLs. This inclusive perspective means that a Caregiver Assessment may possibly be done for any or all the following:
  - Primary caregiver (spouse, partner, daughter, son)
  - Other family members
  - Friends
  - Neighbors

### 2.2 CONDUCTING THE CAREGIVER ASSESSMENT

The SC will:

- conduct a Caregiver Assessment when performing an initial, follow-up, status change or annual MDS-HC assessment/reassessment with the individual. Often a caregiver prefers to speak candidly without being heard by the individual. If this is the preference of the caregiver, make arrangements to do the Caregiver Assessment with the caregiver at a different time. A Caregiver Assessment may be conducted by telephone.
- conduct the caregiver assessment with the "Informal Supports Services" section 2, "Caregiver Status":
  - Ask the questions in Section 2 "Caregiver Status" as they pertain to the MDS-HC.
  - Record the answers in Section 2 "Caregiver Status" of the MDS-HC.
  - Ask the supplemental questions in the Caregiver Assessment.
  - Record the answers on the Caregiver Assessment.

The supplemental questions are for care planning and will not be recorded or scored in the MDS-HC.

### ***2.3 CONDUCTING THE PLAN OF CARE***

The SC will:

- develop the Plan of Care (POC).
- identify the issues or needs discovered through the Caregiver Assessment.
- Use the Caregiver Assessment job aid as a guideline and correlate the issues/needs of the caregiver with a possible strategy/intervention.
- Discuss the strategy/intervention with the individual and the caregiver at the POC meeting.
  - If the individual and caregiver agree with the strategy/intervention and the strategy/intervention is within the scope of the budget, then include the service and/or referral in the POC.
  - If the participant and caregiver suggest alternative strategy/interventions which are within the scope of their budget, then include the service in the POC.
    - If the strategy/intervention is not within the scope of the budget, then the SC will:
      - Review all services and consider a different service mix.
      - Propose an alternative service mix to the individual and caregiver

The SC will revise the POC based upon discussion and approval of the individual and caregiver.

## 3.0 SERVICE HOUR ALLOCATION OF RESOURCES (SHARe) EXCEPTIONS PROCEDURES

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### 3.1 INSTITUTIONAL RISK CAP AND DISABLED OR NO CAREGIVER

#### 3.1.1 OVERVIEW

Office of Aging and Adult Services (OAAS) may grant exceptions to the Service Hour Allocation of Resources (SHARe) if the participant may need additional services to avoid entering a nursing facility.

#### 3.1.2 PROCEDURES

For initials, annuals, significant status changes and/or follow-ups when participants may be in jeopardy of entering a nursing facility, the support coordinator (SC) will:

- Complete the MDS-HC assessment/reassessment. (Refer to Assessment/Reassessment Procedures.)
- Develop the Plan of Care. (Refer to POC Development Procedures.)
- Review the current Minimum Data Set-Home Care (MDS-HC) assessment/reassessment and/or Plan of Care (POC) to determine:
  - if the participant triggered Institutional Risk (IR) CAP; AND
  - if the participant has no informal support (caregivers) OR his/her informal support (caregiver) is disabled.

**NOTE: If a family member provides both paid and unpaid support, the number of hours of natural support should be captured in Informal Supports (Section G of MDS-HC), and the paid support is captured in Service Utilization (Section P of MDS-HC).**

The SC will:

- Submit entire POC packet to SC Supervisor to review.

The SC Supervisor will:

- Review the entire POC packet (Refer to POC Development Meetings Procedures/SC Supervisor Review Procedures) and if he/she determines that the above criteria apply, then the entire POC packet will be sent to R.O. for further review.

The R.O. will:

- Review POC packet and determine if the SHARe Exception should be granted for this participant and appropriate amount.
  - If exception warranted, R.O. will send email with specifics to SC and SC Supervisor.

The SC will:

- Document this exception in the notebook section of the MDS-HC face sheet. The notebook entry must include the following:
  - MDS-HC identifier #;
  - MDS-HC date; and
  - The following statement: “An adjustment to the plan of care (POC) has been authorized by OAAS on (INSERT DATE of OAAS Authorization). As part of our ongoing evaluation and quality audit, we have determined that this participant’s SHARe allotment must not exceed \$XX,XXX. Plan of Care (POC) will be adjusted as necessary.”

**EXAMPLE of MDS-HC Face Sheet Notebook Entry:**

**MDS-HC ID#12345678/Date: 09/01/2011 - An adjustment to the plan of care (POC) has been authorized by OAAS on 10/01/2011. As part of our ongoing evaluation and quality audit, we have determined that this participant's SHARe allotment must not exceed \$40,046. Plan of Care (POC) will be adjusted as necessary.**

- Revise the POC (flexible schedule and budget worksheet) to reflect the new budget amount for the participant.
- Submit entire POC packet to SC Supervisor for approval (Refer to POC Development Meetings Procedures/SC Supervisor Review Procedures).

**NOTE: When SC Agency submits appropriate POC pages to Data Management Contractor, SHARe Exception approval email must also be sent.**

## ***3.2 TOP OF RUG CATEGORY AND 14 OR 15 ADL INDEX SCORE***

### **3.2.1 OVERVIEW**

Office of Aging and Adult Services (OAAS) may grant exceptions to the Service Hour Allocation of Resources (SHARe) based on regional office (R.O.) and/or state office (S.O.) review for those individual's that are at the top of a RUG category **AND** his/her ADL Index Score is a 14 or 15 to avoid those individuals entering a nursing facility.

### **3.2.2 PROCEDURES**

For initials, annuals, significant status changes and/or follow-ups the support coordinator (SC) will:

- Complete the MDS-HC assessment/reassessment. (Refer to Assessment/Reassessment Procedures.)
- Develop the Plan of Care. (Refer to POC Development Procedures.)

**NOTE: The flexible schedule and budget worksheet should NOT exceed the maximum SHARe allocation for the individual's RUG Score.**

- Review the participant's RUG Score and ADL Index Score.

The SC will:

- Submit entire POC packet to SC Supervisor to review.
- If the individual is at the top of a RUG category **AND** his/her ADL Index Score is a 14 or 15, the SC can make recommendations to the SC Supervisor to request an exception to the SHARe allocation for the individual's RUG Score.

The SC Supervisor will:

- Review the entire POC packet (Refer to POC Development Meetings Procedures/SC Supervisor Review Procedures) and if he/she determines that the above criteria apply, then the entire POC packet will be sent to R.O. for further review.

**NOTE: For initial cases ONLY, the SC Supervisor must also do a home visit before sending to R.O. for review.**

The R.O. will:

- Review POC packet and determine if the SHARe Exception should be granted for this participant and appropriate amount.
  - If exception warranted, R.O. will send email with specifics to SC and SC Supervisor.

The SC will:

- Document this exception in the notebook section of the MDS-HC face sheet. The notebook entry must include the following:
  - MDS-HC identifier #;

- MDS-HC date; and
- The following statement: “An adjustment to the plan of care (POC) has been authorized by OAAS on (INSERT DATE of OAAS Authorization). As part of our ongoing evaluation and quality audit, we have determined that this participant’s SHARe allotment must not exceed \$XX,XXX. Plan of Care (POC) will be adjusted as necessary.”

**EXAMPLE of MDS-HC Face Sheet Notebook Entry:**

**MDS-HC ID#12345678/Date: 09/01/2011 - An adjustment to the plan of care (POC) has been authorized by OAAS on 10/01/2011. As part of our ongoing evaluation and quality audit, we have determined that this participant’s SHARe allotment must not exceed \$40,046. Plan of Care (POC) will be adjusted as necessary.**

- Revise the POC (flexible schedule and budget worksheet) to reflect the new budget amount for the participant.
- Submit entire POC packet to SC Supervisor for approval (Refer to POC Development Meetings Procedures/SC Supervisor Review Procedures).

**NOTE: When SC Agency submits appropriate POC pages to Data Management Contractor, SHARe Exception approval email must also be sent.**

### ***3.3 PERSONAL ASSISTANCE SERVICES (PAS) CONVERSIONS***

#### **3.3.1 OVERVIEW**

In July 2010, the Office of Aging and Adult Services (OAAS) created Personal Assistance Services (PAS) and ceased Companion Services in the Elderly and Disabled Adult (EDA) Waiver program. At that time, OAAS combined the total number of Companion Services and Long Term-Personal Care Services (LT-PCS) hours to create the participant’s new total hours for Personal Assistance Services (PAS), even if the amount exceeded the maximum annual SHARe allocation for his/her RUG score OR the maximum SHARe allocation in effect at that time.

If the participant's RUG Score changes, but the participant's functional needs have stayed the same or worsened (i.e. ADL Index Score is higher) **AND** both RUG categories have the same maximum budget allocation, then the participant should receive the same budget as the previous year.

**EXAMPLES of PAS Conversions:**

- ❖ **Participant's 2009-2010 Plan of Care (POC) was approved for 20 hours of Companion Score remained the same and there were no significant changes, his 2010-2011 POC was approved for 30 hours of PAS (even though his budget amount exceeded the maximum annual SHARe allocation for his RUG score).**
- ❖ **If the participant had a RUG Score of 7.41 & 13 ADL Index Score for the last assessment; but his/her current reassessment shows RUG Score 4.31 & 13 ADL Index Score, then previous budget amount should stay the same.**

### 3.3.2 PROCEDURES

For annuals, significant status changes and/or follow-ups that were previously approved by OAAS for a SHARe exception for a PAS Conversion, the support coordinator (SC) will:

- Complete the MDS-HC assessment/reassessment. (Refer to Assessment/Reassessment Procedures.)
- Review the participant's RUG Score and determine:
  - if the participant's SHARe RUG Score remains the same as the previous MDS-HC assessment; **OR**
  - if the participant's RUG Score changes, but the participant's functional needs have stayed the same or worsened (i.e. ADL Index Score is higher) **AND** both RUG categories have the same maximum budget allocation; **AND**
  - **NONE** of the following is applicable:
    - the reassessment indicates that the participant's functioning level has significantly improved, or
    - the participant has requested fewer services, or

- the participant's level of informal, natural, or other community supports has significantly increased.
- The (SC) will:
  - Develop the new POC based on the same number of PAS hours previously approved, even if the amount exceeds the maximum annual SHARe allocation for his/her RUG score OR the current maximum SHARe allocation.
  - Document this exception in the MDS-HC face sheet notebook. The notebook entry shall include the following:
    - MDS-HC identifier #;
    - MDS-HC date; and
    - The following statement: "An adjustment to the plan of care (POC) has been authorized by OAAS on (INSERT DATE of OAAS Authorization). As part of our ongoing evaluation and quality audit, we have determined that this participant's SHARe allotment must not exceed \$XX,XXX. Plan of Care (POC) will be adjusted as necessary."

**EXAMPLE of MDS-HC Face Sheet Notebook Entry:**

**MDS-HC ID#12345678/Date: 09/01/2011 - An adjustment to the plan of care (POC) has been authorized by OAAS on 10/01/2011. As part of our ongoing evaluation and quality audit, we have determined that this participant's SHARe allotment must not exceed \$41,125. Plan of Care (POC) will be adjusted as necessary.**

If reassessment indicates improvement (including increases in informal, natural or other community supports) OR participant requests fewer services, the SC will:

- Develop the POC based on the new MDS-HC reassessment.
- Submit entire POC packet to SC Supervisor to review.

The SC Supervisor will:

- Review the entire POC packet (Refer to POC Development Meetings Procedures/SC Supervisor Review Procedures.)

**NOTE: When SC Agency submits appropriate POC pages to Data Management Contractor, copy of MDS-HC Face Sheet Notebook must also be sent.**

## **4.0 NOTIFICATION OF ADMISSION, STATUS CHANGE, OR DECERTIFICATION/DISCHARGE FOR HCBS WAIVER (148-W) PROCEDURES**

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The 148-W is used by Support Coordination Agencies (SCA) to notify local Medicaid, Data Management Contractor and/or OAAS Regional Offices (R.O.) of:

- Admissions to waiver;
- Discharges from waiver;
- Deaths;
- Demographic changes (For address and phone number changes, update CMIS and send 148-W to Medicaid and R.O. Do NOT send 148-W to Data Management Contractor.);
- Transitions (i.e. from Nursing Facility; to Waiver, Didn't Occur, Inactive Status to Active Status, etc.);
- Transfers (i.e. SC Agencies, Regions/Parishes, etc.); and
- Temporary leave (i.e. participant goes to rehab hospital or nursing facility for short period, etc.).

The support coordinator (SC) will complete the following items on all 148-W forms.

- Support Coordinator Agency;
- Medicaid Provider #;
- Support Coordinator Address;
- Region #;
- Telephone #;
- Fax #;
- Parish; and
- Waiver (Indicate appropriate waiver.)

#### **4.1 SECTION I: PARTICIPANT/MEDICAID ELIGIBLE INFORMATION**

Indicate accurate and current demographic information on the individual and the name and contact information of the responsible representative and/or curator.

The SCA will complete the following sections (II, III, & IV), if applicable.

#### **4.2 SECTION II: ADMISSION INFORMATION**

- A. Program Linkage Date – Indicate the date that the individual was linked to the SCA.
- B. Indicate (from Section V) the place the participant resided prior to being admitted or linked to the waiver program (i.e. If the individual is currently residing in a NF, the SC will indicate that information in this box.).
- C. Indicate intended payment source.
- D. Indicate the transfer date and the parish.
- E. Indicate the name of the waiver that the participant is transitioning from and to and the date of the transition.
- F. Indicate the date that the NF resident was approved for waiver services. (Indicate the same date that the SC Supervisor completes & signs the 142.)

#### **4.3 SECTION III: STATUS CHANGE (Includes Transfers)**

- A. Indicate the *effective date* the participant entered a facility on a temporary basis. If an acute care hospital stay immediately preceded temporary placement, indicate the date of the acute care hospital admission. Indicate the *name of the facility* to which the participant was temporarily placed. Select box or indicate the *type of facility* to which the participant was placed.
- B. Indicate the *date* the waiver participant returned from temporary placement to waiver services.
- C. Indicate the Parish that the participant transferred to and from and the *date of transfer*.
- D. Indicate the name of the waiver that the participant transitioned from and to and the date of transition.
- E. Indicate the name of the SCA the participant is transferring from and to and the date.

- F. Indicate the date that the SCA confirms that the participant CANNOT move out of the Nursing Facility.

#### **4.4 SECTION IV: DISCHARGE or DEATH NOTICE (Permanent Discharges Only)**

- A. Indicate, from Section V, the place to which the waiver participant is being permanently discharged.

Indicate the reason for discharge.

OAAS R.O. will indicate the date the support coordination agency was notified by OAAS R.O. that the participant was discharged from the waiver.

- B. Indicate the date of death.

#### **4.5 SECTION V: SOURCE OF ADMISSION or DISCHARGE DESTINATION**

This section includes a list of possible sources of admission and discharge destinations. When these sources are used to complete Sections I-IV, **specify the name and address** where applicable.

SC will:

- sign & date the day that the 148-W form is completed.

R.O. will:

- review all appropriate discharge documents and approve the discharge information in Section IV and enter the *date* the form is completed.

**NOTE: OAAS Waiver Representative will ONLY review and approve permanent discharges, not deaths.**

For permanent discharges (NOT including deaths), the SC will:

- fax the completed 148-W form and other appropriate documents; Declination Letter (if applicable), Narrative (if applicable), etc.) to R.O. for action.

R.O. will:

- review all appropriate discharge documents and if discharge is appropriate.
- email/scan the 148-W to local Medicaid office and Data Management Contractor and SC the same day that the 148-W is signed and completed.

SC will:

- complete the CMIS closure form and close the participant's case in CMIS the same day that the SCA receives the signed 148-W from R.O.
- fax the CMIS closure form & 148-W to provider(s) on the same day that the forms are completed.

**NOTE: For deaths, the SC must complete the Critical Incident Report (CIR) in W-OTIS before closing the case in CMIS.**

For all other types of notices (including deaths), the SC will:

- fax the completed 148-W form to the Data Management Contractor and local Medicaid Office for action on the same day that the form is completed.
- fax a copy of the completed form and CMIS Closure form to R.O. for their records only on the same day that the forms are completed.

## 5.0 NOTICE OF MEDICAL CERTIFICATION INSTRUCTIONS (Form 142) PROCEDURES

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Form 142 is used by the Support Coordination Agencies (SCA) to notify the local Medicaid Office, OAAS Regional Office (R.O.) and the Data Management Contractor that the individual has met medical eligibility (waiver criteria) for waiver services. This form must be completed on ALL initials (i.e. transitioning from Adult Day Health Care (ADHC) Waiver to Community Choices Waiver (CCW); transitioning from a Nursing Facility (NF) to CCW; transitioning from LT-PCS to CCW, etc.).

**NOTE: If the individual does NOT meet medical eligibility (waiver criteria) for waiver services, OAAS R.O. will complete the 142 and send to local Medicaid Office, the Data Management Contractor and the SCA.**

- Primary Diagnosis & Secondary Diagnosis (ICD-9 Codes)  
([www.medilexicon.com](http://www.medilexicon.com) or [www.icd9data.com/](http://www.icd9data.com/) or [www.epocrates.com/.](http://www.epocrates.com/))
- SSN
- Date of Birth
- Medicaid No:
- To: (Name of Participant)
- Home Address: (of Participant)
- Facility/Provider Name: Indicate the name of the SC Agency
- Vendor No.: Indicate the provider # of the SC Agency.
- Facility Address: Indicate the address of the SC Agency.
- Parish: Indicate the appropriate parish of the participant.
- (if Medicaid applicant in facility) – Do **NOT** complete this line. This line applies to Nursing Facility Admissions **ONLY**.

### ***5.1 SECTIONS I and II:***

**Do not complete these two (2) sections.**

### ***5.2 SECTION III. WAIVER/PACE***

**A. Approved for Medicaid medical eligibility:** (Indicate CCW.)

**Waiver Services effective:** (Indicate the date that the Plan of Care (POC) is approvable, which is the completion date of the 142 form.)

**B. Not Approved - Does not meet Medicaid medical eligibility.** (Check box when individual does not meet waiver criteria.)

Do **NOT** Complete C. on ANY Waiver cases.

**C. Date of Home Visit:**

**D. Vendor Payment May Begin:** (Indicate the date of receipt of the Medicaid Decision Notice - Approval).

**Date completed:** (Do **NOT** complete this line.)

#### **EXCEPTION:**

If currently receiving LT-PCS ONLY or ADHC Waiver, “Vendor Payment May Begin Date” will be fourteen (14) calendar days from the date of the Medicaid Decision Notice (Approval).

**Agency Representative:**

The form shall be signed and dated by the SC Supervisor.  
Do **NOT** indicate the OAAS R.O. name and address.

The SC Supervisor must fax a copy of the completed 142 to the local Medicaid Office (must specify parish) on the day that the 142 is completed and signed.

On the same date that the SCA receives the Medicaid Decision Notice, the SC Supervisor completes III.D. "Vendor Payment May Begin" and the "CC:" [Facility/Provider; OAAS & Other (if applicable)], the SC Supervisor must fax a copy of the completed form along with the applicable documents to OAAS R.O.; Data Management Contractor; provider(s); others (if applicable).

## 6.0 APPEAL PROCEDURES

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When Support Coordinators review the Rights and Responsibilities with the individuals, they must inform them of their fair hearing rights as described below.

Individuals have the right to appeal any agency action or decision and have the right to a fair hearing of the appeal in the presence of an impartial hearing officer. They have the right to request a fair hearing for services which have been denied, not acted upon with reasonable promptness, suspended, terminated, reduced or discontinued, La. R.S. 46:107. A person may file an administrative appeal to the Division of Administrative Law (DAL) regarding the following determinations:

- Denial of admission to waiver services;
- Involuntary reduction or termination of a support or service (due to reduction in budget allocation);
- Discharge from waiver services; and/or
- Other cases as stated in office policy or as promulgated in regulation.

All written appeal requests **MUST** include the following information:

- Individual's name;
- Individual's Social Security Number; **AND**
- Name of Waiver Program: Community Choices Waiver (CCW)

The appeal request must be sent to the following:

Division of Administrative Law – Health and Hospitals Section  
P.O. Box 4183  
Baton Rouge, LA 70821-4183  
Fax #: 225-219-9823

If the individual is unable to mail or fax the appeal request, he/she may call 225-342-5800 to request an appeal.

Anyone requesting an appeal has the right to withdraw the appeal request at any time prior to the hearing by contacting DAL directly.

## ***6.1 INITIAL DENIALS***

Individuals that are denied for initial waiver cases are sent appeal rights from the R.O. giving them thirty (30) calendar days from date of notice to appeal the decision.

## ***6.2 INVOLUNTARY REDUCTIONS, TERMINATIONS AND/OR DISCHARGES***

Individuals that are discharged or terminated from waiver cases are sent a letter by R.O. providing fourteen (14) calendar days advance and adequate notification of any proposed discharge or termination of waiver services.

Individuals that receive an involuntary reduction based on budget allocation are sent a notice by SC Agency providing fourteen (14) calendar days advance and adequate notification of any proposed reduction.

**NOTE: This notice is included on the Plan of Care (POC) document.**

These notices include:

- instructions for requesting a fair hearing; and
- notification that an oral or written request must be made within fourteen (14) calendar days of effective date of proposed adverse action by OAAS in order for current waiver services to remain in place during the appeal process.

- notification that an oral or written appeal request must be made within thirty (30) calendar days from date of notice.

If the appeal request is not made within fourteen (14) calendar days, but is made within thirty (30) calendar days, all Medicaid waiver services are discontinued on the fifteenth (15<sup>th</sup>) working day and **NOT** billable under the waiver program.

## **6.3 PROCEDURES**

### **6.3.1 INITIAL DENIALS**

If the SC Supervisor determines that the individual needs to be denied initial waiver services for any reason, the entire POC packet must be sent to R.O. for further review.

If R.O. determines that the individual needs to be denied waiver services, R.O. will issue a denial notice to participant and send a copy to the SC Agency.

If the individual appeals timely (within 30 calendar days of notice), DAL will send the appeal request and request for Summary of Evidence (SOE) to R.O.

R.O. will:

- prepare and submit SOE to DAL within seven (7) working days of SOE request from DAL.

DAL notifies individual (appellant) and R.O. of appeal hearing date.

R.O. notifies the SC of the appeal hearing date.

Appeal hearing is conducted by DAL Judge.

- SC (and appellant) participates in the hearing (by phone or in person).

DAL sends final decision notice to R.O. and appellant.

- If DAL rules in favor of the appellant, R.O. will contact SC Agency to continue processing his/her waiver case.

- If DAL rules in favor of OAAS, R.O. will complete a 142 denial and email/scan a copy to local Medicaid office, Data Management Contractor and the SCA.
  - The SC will close the waiver case in CMIS.

If the individual does NOT appeal within the thirty (30) calendar days from date of notice,

- R.O. will complete a 142 denial and email/scan to Data Management Contractor, local Medicaid office and SCA.
- The SC will close the waiver case in CMIS.

### 6.3.2 DISCHARGES/TERMINATIONS

If the SC Supervisor determines that the participant meets waiver discharge criteria (other than death), the entire POC packet (including all information to support discharge) will be sent to R.O. for further review.

If R.O. determines that the individual meets waiver discharge criteria, R.O. will issue a discharge notice to participant and send a copy to the SC Agency.

If individual appeals timely (within fourteen (14) calendar days of the date of the proposed discharge/termination), R.O. will send a POC Extension request to the Data Management Contractor and copy to the SC Agency so the participant can continue to receive services throughout the appeal process.

The SC will notify the provider of the appeal request and POC Extension.

**NOTE: If the current POC has an end date of ten (10) days or greater from the date of the discharge notice, a POC extension IS NOT needed.**

DAL will send the appeal request and request for a Summary of Evidence (SOE) to R.O.

R.O. will:

- prepare and submit SOE to DAL within seven (7) working days of SOE request from DAL.

DAL notifies individual (appellant) and R.O. of appeal hearing date.

R.O. notifies the SC of the appeal hearing date.

Appeal hearing is conducted by DAL Judge.

- SC (and appellant) participates in the hearing (by phone or in person).

DAL sends final decision notice to R.O. and appellant.

- If DAL rules in favor of the appellant, R.O. will contact SC Agency to continue with his/her waiver case.
- If DAL rules in favor of OAAS, R.O. will request a 148-W discharge from the SC.
  - The SC will complete and fax the following documents (indicating reason for discharge) to R.O:
    - the 148-W discharge with a discharge effective date one day after the date the decision is received from DAL.
  - R.O. signs the 148-W and emails/scans to Data Management Contractor, local Medicaid office and SCA.
  - SC closes the participant's case in CMIS and faxes the notice to the provider(s).
  - SC calls and speaks with a representative of the provider(s) to inform them of the discharge and by fax notification.

If the participant DOES NOT appeal within fourteen (14) calendar days of the date of the proposed discharge/termination, services will be terminated effective the fifteenth (15<sup>th</sup>) day.

If the participant does NOT appeal within the fourteen (14) calendar days of the date of the proposed termination, R.O. will wait the thirty (30) calendar days from date of notice to see if participant will file an appeal.

If the participant appeals timely (within thirty (30) calendar days from the date of discharge notice), DAL will send an appeal request and a request for Summary of Evidence (SOE) to R.O.

R.O. will:

- prepare and submit SOE to DAL within seven (7) working days of SOE request from DAL.

DAL notifies individual (appellant) and R.O. of appeal hearing date.

R.O. notifies the SC of the appeal hearing date.

Appeal hearing is conducted by DAL Judge.

- SC (and appellant) participates in the hearing (by phone or in person).

DAL sends final decision notice to R.O. and appellant.

- If DAL rules in favor of the appellant, R.O. will contact SC Agency to continue with his/her waiver case effective the receipt date of the decision.
- If DAL rules in favor of OAAS, R.O. will request a 148-W discharge from the SC.
  - The SC will complete and fax the following document (indicating reason for discharge) to R.O:
    - the 148-W discharge with a discharge date one day after the date the decision is received from DAL.
  - R.O. signs the 148-W and emails/scans to Data Management Contractor, local Medicaid office and SCA.
  - SC closes the participant's case in CMIS and faxes the notice to the provider(s).
  - The SC calls and speaks with a representative of the provider(s) to inform them of the discharge and by fax notification.

If the individual does NOT appeal within the thirty (30) calendar days from date of notice, the participant's waiver case will be closed.

- R.O. will request a 148-W discharge from the SC.
  - The SC will complete and fax the following document (indicating reason for discharge) to R.O:
    - the 148-W discharge with the discharge date indicated on the discharge notice.
  - R.O. signs the 148-W and emails/scans to Data Management Contractor, local Medicaid office and SC Agency.
  - SC closes the participant's case in CMIS and faxes the notice to the provider(s). The SC calls and speaks with a representative of the provider(s) to inform them of the discharge and by fax notification.

### 6.3.3 INVOLUNTARY REDUCTIONS

Once the SC Supervisor reviews the entire POC packet and determines that the participant's budget allocation will be reduced from previous allocation, the participant must receive adequate notice with fair hearing rights.

**NOTE: This reduction notice is included on the Plan of Care (POC) document.**

When the SC Supervisor signs off on the POC indicating the reduction in services, the SC Agency must:

- send entire POC packet (including MDS-HC Assessment) to the participant fourteen (14) calendar days prior to the start date of the new POC.
- send copy of entire POC packet to R.O.

If the participant appeals timely (within fourteen (14) calendar days of the date of the proposed reduction), R.O. will send a POC Extension request to the Data Management Contractor and copy to the SC Agency so current services can continue.

The SC will notify the provider(s) of appeal request and POC Extension.

DAL will send an appeal request and a request for Summary of Evidence (SOE) to R.O.

R.O. will:

- prepare and submit SOE to DAL within seven (7) working days of SOE request from DAL.

DAL notifies individual (appellant) and R.O. of appeal hearing date.

R.O. notifies the SC of the appeal hearing date.

Appeal hearing is conducted by DAL Judge.

- SC (and appellant) participates in the hearing (by phone or in person).

DAL sends final decision notice to R.O. and appellant.

- If DAL rules in favor of appellant, R.O. will contact SC Agency to continue with his/her waiver services as per instructions from DAL.
- If DAL rules in favor of OAAS, R.O. will contact SC Agency to proceed with new proposed POC that indicates reduction in services.
- The SC calls and speaks with a representative of the provider(s) to inform them of the appeal decision and by fax notification.

If participant does NOT appeal within the fourteen (14) calendar days of the date of the proposed reduction, the new POC (with reduction in services) will begin on date indicated on the POC form as "POC Begin Date".

If participant appeals timely (within thirty (30) calendar days from the date of reduction notice), DAL will send appeal request and request for Summary of Evidence (SOE) to R.O.

R.O. will:

- prepare and submit SOE to DAL within seven (7) working days of SOE request from DAL.

DAL notifies individual (appellant) and R.O. of appeal hearing date.

R.O. notifies the SC of the appeal hearing date.

Appeal hearing is conducted by DAL Judge.

- SC (and appellant) participates in the hearing (by phone or in person).

DAL sends final decision notice to R.O. and appellant.

- If DAL rules in favor of appellant, R.O. will contact SC Agency to continue with his/her waiver services as per instructions from DAL.
- If DAL rules in favor of OAAS, R.O. will contact SC Agency to proceed with new proposed POC that indicates reduction in services.
  - The SC calls and speaks with a representative of the provider(s) to inform them of the appeal decision and by fax notification.

## 7.0 REPORTING PROCEDURES

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### 7.1 AGING REPORTS

The Aging Reports (in CMIS and LAWRRIS) lists all of the current linkages which have not been completed for a particular SCA.

This report must be reviewed daily by the SCA staff to ensure linkages are being processed in a timely manner.

Initial waiver cases must be completed (approved or denied by the SC Supervisor) within thirty-five (35) days of linkage notification.

**NOTE: If SC determines that an initial Nursing Facility complex waiver case (i.e. Housing Issue; Receiving Treatment/Rehabilitation services, etc.) CANNOT be completed within the thirty-five (35) day timeline, the SC may want to consider placing the individual on “Inactive” status. Case must be sent to R.O. to approve or deny “Inactive” status.**

### 7.1.1 PROCEDURES

The SC Supervisor will:

- review the CMIS Aging Report daily and assure that linkages are processed and submitted to R.O. and/or Data Management Contractor by the required timeframe.
- submit the Aging Report Log to R.O. on the 1<sup>st</sup> of every month.

The Aging Report Log must include:

- Detailed information on all cases that are over thirty-five (35) days old.
- continue to check/monitor the status of all aging linkages and contact R.O. for needed assistance.

R.O. will:

- review the LAWRRIS Aging Report and compare with the SC’s Monthly Aging Report Log.
- report any discrepancies to the SC Agency and/or Data Management Contractor.
- report invalid reasons for the aging linkages to State Office.

R.O. and/or S.O. may:

- issue notification of sanction to SC Agency as identified in the SC Performance Agreement.

## **7.2 EXPIRED PLANS OF CARE (POCs) REPORTS**

This report must be reviewed daily by the SC Agency staff to ensure that all Annual POCs are being processed in a timely manner.

If the SC Agency does not submit the entire Annual POC packet within the required timeframe, the participant's name will appear on the LAWRRIS Expired Plan of Care (POC) Report.

### **7.2.1 PROCEDURES**

The SC Supervisor will:

- review the SC Agency's internal POC Report daily and make sure that the annual waiver cases (including POCs) are processed and submitted to R.O. and/or Data Management Contractor by the required timeframe.
- submit the Annual POC packet (Demographic page; Signature page; Budget Worksheet & Flexible Schedule) to the Data Management Contractor and a copy of the entire Annual POC packet to R.O. within fourteen (14) calendar days of POC Expiration Date.

**NOTE: POC Expiration Date is the day after the POC End Date.**

- report to R.O. any waiver case that CANNOT be submitted within the required timeframe (Refer to Late POC Procedures).

R.O. will:

- Review the LAWRRIS Expired POC Report and follow-up with the SC Agency and/or Data Management Contractor.
- Report invalid reasons for the expired POCs to State Office.

R.O. and/or S.O. may:

- Issue notification of sanction to SC Agency as identified in the SC Performance Agreement.

### **7.3 EVACUATION TRACKING FORM FOR WAIVER PARTICIPANTS**

This report must be completed on all waiver participants. This form must be updated monthly during Hurricane season or weekly during an emergency event or more frequently if identified by OAAS. During Hurricane season, this form must be sent electronically to R.O. on the 15<sup>th</sup> of every month (beginning June 15<sup>th</sup> through the end of November).

- If any changes to the Emergency Plan have been identified during the monthly or quarterly contact with the participant, the SC must update the Evacuation Tracking Form to reflect this information.
- When an evacuation has occurred, the Evacuation Tracking Form must be completed and sent electronically to R.O. weekly (due every Friday) until all evacuated participants have returned home.

## **8.0 APPENDIX**

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## *Appendix A:*

### **Data Management Contractor Problem Sheet Procedures**

The Support Coordination Agency (SCA) submits Plan of Care Packets (appropriate identified pages) to the Data Management Contractor.

If problems are identified by the Data Management Contractor, the problem sheet will be sent directly to the SCA with a copy to Regional Office (R.O.).

- The SCA must correct the issues identified by the Data Management Contractor and send corrections to Data Management Contractor with a copy to R.O. within three (3) working days.

**NOTE: If the correction is not received back to the Data Management Contractor by the required timeline, Data Management Contractor will send out a second (2<sup>nd</sup>) notice (indicating 2<sup>nd</sup> Notice) to the SCA with a copy to R.O. & R.O. will follow-up with the SCA.**

## *Appendix B:*

### **Community Choices Waiver Admission and Discharge Criteria**

#### **Admission Criteria**

Admission to the Community Choice Waiver (CCW) Program will be determined in accordance with the following criteria:

1. initial and continued Medicaid financial eligibility;
2. initial and continued eligibility for nursing facility level of care;
3. justification, as documented in the approved POC, that the CCW services are appropriate, cost effective and represent the least restrictive environment for the individual; and
4. assurance that the health and welfare of the individual can be maintained in the community with the provision of the CCW services.

Failure of the individual to cooperate in the eligibility determination process or to meet any of the criteria in the above will result in admission denial to the CCW.

#### **Denial or Discharge Criteria**

Admission will be denied or the individual will be discharged from the CCW Program if any of the following conditions are determined.

1. The individual does not meet the criteria for Medicaid financial eligibility.
2. The individual does not meet nursing facility level of care criteria.
3. The individual resides in another state or has a change of residence to another state.
4. Continuity of services is interrupted as a result of the individual not receiving and/or refusing CCW services (exclusive of Support Coordination services) for a period of thirty (30) consecutive days.

**Exception: The individual is temporarily admitted to an acute care hospital, rehabilitation hospital or a nursing facility for a stay up to ninety (90) consecutive days.**

5. The individual's health and welfare cannot be assured through the provision of the CCW within the participant's cost effectiveness.
6. The individual fails to cooperate in the eligibility determination process or in the performance of the Plan of Care (POC).
7. Failure on behalf of the individual to maintain a safe and legal home environment.
8. It is not cost effective to serve the individual in the CCW.