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200 - THE CCSP

200 -THE COMMUNITY CARE SERVICES PROGRAM

POLICY STATEMENT	The CCSP provides Medicaid-funded, community-based services to eligible functionally impaired individuals as an alternative to institutional placement.
POLICY BASICS	The purpose of the CCSP is to assist those who are aged (65 and older) and physically disabled live dignified and reasonably independent lives in their own homes or in homes of relatives or caregivers. Enabling legislation for the CCSP includes: the 1982 Community Care and Services for the Elderly Act and the federal 1981 Omnibus Budget Reconciliation Act establishing the federal 1915(c) Home and Community-Based Services Medicaid Waiver Program. Protection of client rights is an integral feature of the program. The program supports the following for people with functional impairments: • A continued ability to live in the community while receiving services • A continued choice in living arrangements and kinds of services received. The CCSP is based on the premise that it is desirable to enable functionally impaired persons to reside at home or with their families. Some individuals, however, require more care than can be provided at home or in the community; therefore, it is not always possible or feasible to prevent or delay institutional placement. CCSP goals are achieved through the development of a system of community health and social services which provide a continuum of care for functionally impaired clients to assure that the least restrictive living arrangement is used to maintain independence and safety in the community. Access to the CCSP is achieved through determination of financial eligibility by the county Division of Family and Children Services (DFCS) and an assessment of the individual's need for long term care using criteria established for nursing home placement. The assessment function is carried out by the Area Agencies on Aging and/or their care coordination subcontractors.

POLICY BASICS (contd.)	The CCSP utilizes a care coordination process (which includes telephone screening, assessment, brokering of services, and reassessment) and an array of in-home and community-based services designed to prevent unnecessary or premature institutional placement. CCSP services include the following: • Adult Day Health • Alternative Living Services • Emergency Response • Home Delivered Meals • Home Delivered Services • Personal Support/Extended Personal Support • Out-of-Home Respite. State, federal, and local agencies and businesses coordinate with each other to deliver services to CCSP clients. Service delivery occurs at the local level. The Division of Aging Services administers the program in coordination with the Department of Community Health (DCH). AAAs provide for local program management and coordination. Service providers approved by the Division of Aging Services and enrolled with the DCH deliver CCSP services. Enrolled service providers submit claims to DCH for payment.
PROCEDURES	A care coordinator or AAA telephone screening specialist completes a telephone screening to determine a referral's potential eligibility for CCSP and to establish priority for initial assessment. A registered nurse (RN) uses a standard format to complete initial assessments to determine eligibility for CCSP services. During assessment, the care coordinator (RN) determines whether a client meets the eligibility criteria and service(s) a client needs. The applicant's physician provides medical information which the care coordinator uses to complete the plan of care and determine whether
PROCEDURES (contd.)	the applicant meets the level of care criteria for nursing facility

	placement. Upon a physician's concurrence, care coordination implements the recommended care plan developed at the time of assessment. The care coordinator authorizes, brokers and manages services for a client to assure that the most appropriate services are provided in a timely and cost effective manner. Enrolled service providers deliver the services needed by a client. Care coordinators arrange non-Medicaid services as needed through other community resources. The care coordinator routinely reviews each client's care plan and adjusts it depending upon changes in a client's condition or circumstances. The care coordinator reassesses each CCSP client and redetermines a client's level of care at least annually.
REFERENCES	Section 210, 1981 Omnibus Budget Reconciliation Act; Section 230, 1982 Georgia Community Care and Services for the Elderly Act; Chapter 300, Administrative Organization

210 - 1981 OMNIBUS BUDGET RECONCILIATION ACT

POLICY STATEMENT	The federal 1981 Omnibus Budget Reconciliation Act (OBRA) established funding for the CCSP through the 1915(c) Home and Community-Based Services Medicaid Waiver Program.
POLICY BASICS	The Home and Community-Based Services Medicaid Waiver Program allows states to provide noninstitutional services, reimbursable by Medicaid, to individuals at risk of institutional placement or who are receiving institutional care and need help in returning to the community.
PROCEDURES	To participate in a Medicaid waiver program, states apply to the Centers for Medicaid and Medicare Services (CMS) for a Medicaid waiver. In designing waiver programs, states are allowed to: • Identify a target population to be served • Limit participation to specific ages, diagnoses, and geographic areas • Limit the total number of persons to be served • Include social services which would ordinarily be excluded from Medicaid coverage • Provide Medicaid services to persons who would otherwise be ineligible. CMS approves Medicaid waivers for states which provide the following: • Safeguards to protect the health and welfare of participants • Evaluation of applicants to determine eligibility for nursing home care, and assessment of those who meet this level of care test • Choices for applicants between waivered services and nursing home care • Assurance that average per capita expenditure for medical assistance with the waiver is not greater than average per capita expenditure would be without the waiver.
REFERENCES	Section 210, 1981 Omnibus Budget Reconciliation Act;

The 1915(c) Home and Community-Based Medicaid Waiver

220 - WAIVERED SERVICES

POLICY STATEMENT	CCSP clients receive certain services, not normally reimbursable by Medicaid, as set forth in the federal 1981 Omnibus Budget Reconciliation Act. These services are called "waivered services".
POLICY BASICS	CCSP waivered services are reimbursable by Medicaid (Title XIX). However, services that are reimbursed under the Medicaid waiver may also be provided from a number of funding sources including: • Older Americans Act, Title III • Social Services Block Grant (SSBG) • Medicare. CCSP waivered services include the following: • Adult Day Health (ADH) - Care for dependent adults in a supervised, protective congregate setting during some portion of a 24-hour day. Services typically include therapeutic activities, dietary services, rehabilitation, medications monitoring, and personal care. • Alternative Living Services (ALS) - 24-hour supervision, medically-related personal care, nursing supervision and health- related support services in state-licensed personal care home. • Emergency Response System (ERS) - an in-home electronic support system providing two-way communication between an isolated client and a medical control center, 24 hours a day, 7 days a week. • Home Delivered Meals (HDM) - meals, delivered to a client's home, each of which meets 33 1/3 % of the Recommended Daily Allowance (RDA) and otherwise complies with the American Dietary Association's *Dietary Guidelines for Americans.* • Home Delivered Services (HDS) - Basic medical services provided under medical supervision to individuals who can be cared for at home. Includes care provided by a licensed health professional subsequent to diagnosis of a physical condition; monitoring of treatment plans and nursing and rehabilitation
POLICY BASICS	care such as physical, speech/hearing and occupational therapy

(contd.)	and medical social services. • Personal Support Services (PSS)/Extended Personal Support (PSSX) - Those tasks designed for clients who need assistance with activities of daily living such as: specific errands which enhance the client's being, light housekeeping, and/or basic personal care needs and basic home maintenance, as well as to relieve the person(s) normally providing care/oversight. PSS is not to exceed 5 units. PSSX has a minimum of 6 units. • Skilled Nursing Services (SNS) – Nursing services provided to meet the medical needs of clients when a home health agency is unable to provide the service. These services are performed by a registered nurse, or, in certain cases, a licensed practical nurse in accordance with the plan of care. • Out-of-Home Respite - A non-skilled service that provides temporary relief to the caregiver(s) responsible for performing or managing the care of a functionally impaired person. Respite care is provided in a Division of Aging approved out-of-home respite care setting.
PROCEDURES	Providers enroll with the Division of Aging Services and contract directly with the DCH to provide Medicaid waivered services in specific geographical areas.
REFERENCES	Section 210, 1981 Omnibus Budget Reconciliation Act; CCSP service provider manuals

230 - 1982 GEORGIA COMMUNITY CARE AND SERVICES FOR THE ELDERLY ACT

POLICY STATEMENT	The 1982 Georgia Community Care and Services for the Elderly Act established the CCSP in Georgia and assigns to the Division of Aging Services primary responsibility for program policy development and administration. The Division gives high priority to coordination of various entities working together to provide quality, consumer-focused services.
POLICY BASICS	The legislative intent of the Community Care and Services for the Elderly Act is to: • Assist functionally impaired elderly in living dignified and reasonably independent lives in their own homes or with their families • Establish a continuum of care for such elderly in the least restrictive environment • Maximize use of existing community social and health services to prevent unnecessary placement of individuals in long-term care facilities • Develop innovative approaches to program coordination, staff training and service delivery that impact on cost avoidance, cost effectiveness, and program efficiency. Other major features of the Act: • Coordination of community based services • Provision of a minimum of six services with four required services in each planning and service area (PSA). The four required services are listed below: ◦ Case management (care coordination) ◦ Assessment of functional impairment and needed community services (care coordination) ◦ Homemaker (Personal Support Services) ◦ Home Health Care Services (Home Delivered Services). Additional features of the Act include the following: • Mandatory assessment for individuals seeking nursing facility care funded by Medicaid
POLICY BASICS	

(contd.)

- Administration of the program by a lead agency in each geographic service area.
- Assignment of administrative responsibility to DHR
- Use of a sliding-fee scale.

The 1982 act embraces four major concepts described in Chart 230.1

Chart 230.1 - Major Concepts of 1982 Act

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

PROCEDURES

The 1982 Act requires that DHR establish a community care unit within the Division of Aging Services to perform the following:

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

REFERENCES

The 1982 Georgia Community Care and Services for the Elderly Act;
Chapter 300, Administrative Organization;
Appendix 300, Job Descriptions