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700 - CARE MANAGEMENT

710 - BROKERING SERVICES

POLICY STATEMENT	Brokering, the process of arranging for providers to deliver Medicaid waivered services, will be conducted when admitting new clients or changing services for active clients in accordance with established guidelines.
POLICY BASICS	The Division of Aging Services notifies the AAA of each provider number issued to an enrolled provider. No CCSP clients are referred for services to a CCSP provider until the care coordinator has received the provider's DMA provider number from the AAA. Within three business days of receiving notice of the provider number from the AAA, care coordinators add new providers to the end of the rotation log. Care coordinators and the AAA use an up-to-date list of enrolled providers and their contact persons. The CCSP Aging Information Management System (AIMS) provides a computerized list of enrolled providers for each planning and service area (PSA). If a provider agency fails or declines to offer a service for which it has been approved, the AAA notifies the Division of Aging Services immediately. **NOTE:** All ALS-Family Model family home subcontractors must be registered with the Division of Aging Services. CCSP clients are placed only in approved ALS Family Model homes that appear on the Division's registration list, a copy of which is sent periodically to AAAs and care coordination agencies.
PROCEDURES	Use the following procedures to broker services: 1. Broker service with the provider that the client chose. 2. When clients do not have a provider preference, select the provider from enrolled CCSP providers serving the county where client resides. 3. Maintain a log of referrals for each county. There will be one log per county per service. If a provider delivers more than one service, add the provider to each applicable log. When more than one provider offers the same service, select the provider through the rotation method. Once a provider is given an opportunity to accept a client, move to the next provider on the rotation log, regardless of whether the provider accepted the client.

PROCEDURES (contd.)

NOTE: Care coordinators only refer clients to providers and do not offer opinions about services from providers.

4. Use Chart 710.1 to identify the appropriate method for selecting the CCSP provider:

Chart 710.1 - Provider Selection

IF	THEN
Client selects a CCSP provider **NOTE:** Indicate client provider selection on CCP.	Arrange for the selected provider to begin furnishing services to the client.
Care coordinator calls provider to broker service(s) for a new or active client AND Provider fails to contact care coordinator within 24 hours to indicate that s/he will conduct a face-to-face evaluation within two business days	Immediately, the next business day, broker service(s) with another provider.
Client needs immediate (emergency) services and selected provider is unable to render immediate service	Ask client to choose an alternate provider.
Care coordinator is unable to reach provider within the time frame necessary to begin service for client with emergency need	Contact another provider agency immediately.
Selected provider does not provide services needed	Ask client to choose another provider.
Client does not select a provider	Use rotation to select the provider.
Client declines a referral to a provider selected through rotation	Document client decision in case record. Refer client to next provider name on list. **NOTE:** The provider not selected must wait through the complete rotation before being considered again.
Provider refuses the referral from rotation **NOTE:** Adverse action may be imposed if the provider agency fails to accept referrals without legitimate reasons	Indicate provider's reason for refusal on the rotation log. Provider must wait through the complete rotation before being considered again. Refer client to

IF (contd.)	THEN (contd.)
	next provider on rotation log.
New provider enrolls in CCSP	Add provider to the end of rotation log.

PROCEDURES (contd.)

4. In preparation for brokering services with a provider, review client medical and Medicaid status to:

   - Confirm completeness and accuracy of medical information
   - Check current Medicaid eligibility.

5. Before admitting a client to care coordination, review LOC page, MDS-HC , CCP, and attached information to:

   - Become familiar with client needs before calling the client to discuss admission to CCSP
   - Discuss cost share estimates if client is MAO/PMAO.

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6. Update the CCP with additional information. Discuss changes in the plan of care with the care coordinator RN who completed the assessment to get approval. Document this communication on the CCP, Comment Section.

7. Telephone the selected provider to:

   - Order the specific services needed and their frequencies
   - Explain that a referral packet is forthcoming
   - Advise the provider of client's Medicaid eligibility and discuss estimated client cost share.

8. Immediately forward to providers the referral packets for new clients and reassessment forms or CCPs for active clients in order to:

   - Expedite services to clients by faxing or delivering referral packets to the provider agency, or by having the provider agency pick them up, no later than 24 hours after brokering services.

   - Avoid leaving referral packets in mailboxes unattended while awaiting pickup by the provider agency.

PROCEDURES (contd.)

NOTE: For a new admission, providers complete a client

evaluation visit after they receive a referral packet. If the client is in an emergency situation, providers usually initiate service prior to receipt of the packet; however, the provider may request hand delivery of the packet before beginning services.

9. In the referral packet, include a copy of the following information:

- Copy of LOC page
- MDS-HC and CCP generated from CHAT which includes the following:
  - Client detail
  - Assessment questions short
  - DON
  - Assessment detail
  - Triggers
  - Care plan which includes CAPs and Service Order.
- Copy of signed Authorization for Release of Information and Informed Consent (signature page)
- If client is MAO or PMAO, copy of the completed Potential CCSP MAO Financial Worksheet, which contains client signed Statement of Intent: Cost Responsibility
- Any other relevant information, including:
  - psychological and psychiatric evaluations
  - information about client that the provider needs before completing an evaluation/assessment.

NOTE: Send the Client Referral Form-Home Delivered Meals form to the CCSP HDM provider when brokering this service.

10. Send a copy of the following to providers who deliver services funded by the Older Americans Act, Social Services Block Grant, or other non-Title XIX sources:

- Copy of LOC page and CCP

PROCEDURES (contd.)

- Copy of Authorization for Release of Information and

Informed Consent, signed by client.
Some non-Medicaid providers may require additional information.

11. After brokering services for a new client, complete Community Care Services Program Participation, Form 5389, to notify client of admission to CCSP. List name, contact person, and telephone number for each CCSP provider who will be providing service. Send original to client and retain a copy for the case file.

12. In the case notes, document activities related to service arrangement and communications with client, family, and other service providers.

13. Use the Client Registration Report for AIMS to register the new client in the AIMS database.

Use Chart 710.2 to determine activities involved when responding to provider notifications of changes in client service or situation:

Chart 710.2 Changes in Service Status for Active Clients

IF	THEN
Provider sends 30-day discharge notice to a client and client is still in need of service	Within three business days, contact client to discuss brokering services with another provider Advise new provider of the client's discharge from the previous provider. **NOTE:** Client does not appeal with Legal Services Office (LSO) if a provider sends a 30-day discharge notice to the client.
Provider notifies care coordinator of a change in client status (hospitalization, change of address, death, etc.)	Within 24 hours, contact other providers involved in client care. Monitor client hospital stay to determine if reassessment of service is needed upon discharge.

REFERENCES

Section 602.1 Provider General Manual;
Section 606, Provider General Manual

712 - BROKERING SERVICES FOR MAO/PMAO CLIENTS

POLICY STATEMENT	Clients not otherwise eligible for Medicaid may qualify for the CCSP class of medical assistance through the Medicaid waiver.
POLICY BASICS	When brokering service with a provider, the care coordinator advises provider of client Medicaid eligibility status-SSI Medicaid, MAO, or PMAO-and discusses estimated cost share, if applicable. SSI Medicaid clients are not required to pay toward the cost of their CCSP services, while MAO and PMAO clients are subject to cost shares. At initial assessments, care coordinator RNs advise MAO and PMAO clients of their estimated cost shares and include amounts on PMAO Financial Worksheets and Cost Share Brochure. During the brokering of services, care coordinators review the Medicaid eligibility process with PMAO clients.
PROCEDURES	1. Follow procedures indicated in Section 710. 2. Use procedures in Chart 712.1 below for brokering and authorizing services for MAO and PMAO clients:

Chart 712.1 - Brokering MAO/ PMAO Clients

IF	THEN
Client has a Medicaid card NOTE: Contact DFCS to verify Medicaid eligibility and class of assistance.	Client may be currently Medicaid eligible. Medicaid recipients receive cards with a 12-digit number. These Medicaid numbers do not identify the Medicaid class of assistance.
Client is eligible for a category of Medicaid other than SSI Medicaid	1. Remind the client of cost share responsibility. Explain to clients that failing to pay cost share may put them at risk of losing services. 2. Send a copy of the PMAO Financial Worksheet to the provider with the referral packet or fax the information when possible.

IF (contd.)	THEN (contd.)
	3. After receiving a CCNF verifying that the client is in service, send the CCC , LOC page and copy of MAO Worksheet to DFCS. **NOTE:** When the client meets the CCSP Medicaid LOS, send the second CCC to the DFCS caseworker.
Client is potentially Medicaid eligible	1. Follow steps 1-3 above. 2. Remind client/representative of the Medicaid eligibility process. 3. When sending the CCC and LOC page to DFCS, advise the client to apply for Medicaid. Determine if the client has adequate transportation to attend an appointment. **NOTE**: If the care coordinator sends the Medicaid application with the CCC and LOC page, advise the client to contact DFCS to discuss the interview that needs to occur to determine Medicaid eligibility. 4. Within two weeks of sending the referral and/or application to DFCS, contact the DFCS caseworker to determine the Medicaid application date and if the client has been interviewed. **NOTE:** The application date is the date DFCS receives the Medicaid application. 5. Make a good faith effort to ensure that the client is proceeding with the Medicaid eligibility process. If the client is having difficulty with the Medicaid process, schedule a case conference to determine

IF (contd.)	THEN (contd.)
	ways of providing assistance. 6. Within 45 days of the Medicaid application date, contact DFCS caseworker to determine the client's eligibility status. **NOTE:** If the client's Medicaid application has not been processed, contact DFCS every two (2) weeks until eligibility is established.

REFERENCES	Chapter 600, Care Coordination; Chapter 1100, CCSP AIMS; Appendix 100, Forms and Instructions; Section 606, Provider General Manual

714 - BROKERING EMERGENCY ADMISSIONS

POLICY STATEMENT	Emergency admissions to CCSP must meet the same eligibility requirements imposed on all other CCSP admissions. Emergency cases are determined on a case by case basis and placed into service immediately.
POLICY BASICS	The AAA and care coordinator work closely together to determine if a client is an emergency case.
PROCEDURES	Complete all assessment activities before brokering emergency services. Use the following procedures to begin emergency brokering of services: 1. Telephone the appropriate service provider to obtain a tentative schedule for beginning services. **NOTE:** If unable to reach provider to broker within time frame necessary to begin service, immediately contact another service provider. 2. Fax or send the referral package to the provider as quickly as possible. 3. Contact the referral source, client and/or family to give the schedule for services to begin. 4. Within one week, follow up with client and/or family to confirm that the provider is delivering services as scheduled on the CCNF and as ordered on the CCP. 5. Provide ongoing care coordination services after arranging for services for emergency cases. 6. Assure that the AAA has client name, date of admission to the program, and Medicaid number for the log of emergency admissions. 7. Conduct all the activities required for other clients admitted to CCSP on a non-emergency basis.
REFERENCES	Chapter 600, Care Coordination; Chart 620.3 Assessment Procedures for Emergency Cases; Appendix 100, Forms and Instructions

Section 716 – AUTHORIZING BROKERED SERVICES

POLICY STATEMENT	Authorization for provision of CCSP services to clients and Medicaid reimbursement to providers is delegated to care coordinators.
POLICY BASICS	Care coordinators use the Service Authorization Form (SAF) to authorize services. The SAF is used to manage CCSP costs at both the regional (PSA) and state levels and: • Informs DMA of approved procedures and maximum allowable dollar amounts/services provided. EDS and DMA match SAF information to provider claims before issuing payments. • Establish each client's CCSP anniversary date through the Services Begin Date, the date the client received the first waivered service reimbursed by Medicaid. Before the care coordinator authorizes services, a client must have a valid Medicaid number and be registered in AIMS. The AIMS completes the authorization process electronically.
PROCEDURES	The provider completes the initial face-to-face evaluation of the client's condition within 2 business days of receiving the referral packet from the care coordinator. Client services begin within 48 hours from the face-to-face evaluation. When services begin, the provider RN sends the care coordinator a Community Care Notification Form (CCNF), Form 6500. The CCNF reflects the date services began and frequency of services ordered. **NOTE:** If care coordinators do not receive CCNFs within 3 days of face-to-face evaluation by providers, contact providers to request forms. Use procedures in Chart 716.1 below to respond to providers' initial CCNFs and authorize CCSP services:

Chart 716.1 - Responding to Initial CCNFs

IF	THEN
After provider's initial evaluation, the provider requests change in service	Within three business days, return CCNF advising provider of approval or disapproval of request for change in service.

IF (contd.)	THEN (contd.)
Services and frequency indicated on the provider's initial CCNF are the same as listed on CCP	1. Sign and date CCNF to indicate receipt of the provider's verification of service delivery. AND 2. Within three working days, return a copy of the CCNF to provider. File original in case file.
Services and frequency on provider's initial CCNF do not agree with CCP AND Care coordinator does not agree with provider's service delivery	1. Call the provider to clarify service order. 2. Indicate reasons for denying provider's request for change in service on CCNF. 3. Within three working days, sign the CCNF and return it to provider. 4. If necessary, broker services with another provider.

PROCEDURES (contd.)

If the client is Medicaid eligible, complete the Initial Service Authorization Data Entry Form to authorize services on SAFs. If the client is MAO or PMAO, authorize services after DFCS determines Medicaid eligibility and cost share amount.

Determine if the client received CCSP services in the past. If so, reactivate old client case file.

Send subsequent SAFs to providers at least five working days prior to the month for which services are authorized.

NOTE: AAAs monitor SAF issuances to assure that providers receive them within the specified time frame.

Use procedures in Chart 716.2 to authorize home health visits:

Chart 716.2 - Authorizing Home Health

Client has received less than 50 Medicaid home health	Do not enter the Medicaid Home Health provider on the SAF

visits	
IF (contd.)	**THEN (contd.)**
Client has received 50 Medicaid home health visits but needs additional service	Enter the HDS provider on the SAF for the 51st and subsequent home health visits provided during the remainder of the calendar year **NOTE:** Clients may receive the first 50 visits from a home health agency not enrolled in CCSP.

REFERENCES

Policies and Procedures for Home Health Services
Section 605.2, Provider General Manual

720 - DISCHARGE PLANNING

POLICY STATEMENT	Discharge planning is instituted at the beginning of CCSP participation to assist a client in making the transition from one service environment to another.
POLICY BASICS	Each client admitted to the program has a discharge plan to facilitate transition from one CCSP service to another, or from the CCSP to another service setting. Discharge planning is conducted to: • Plan for continuity of an individual's health care • Maintain the individual's level of functioning • Lower an individual's readmission rates to medical facilities. Discharge planning involves a client's support system and individuals from various disciplines working together to facilitate the transition. In addition to the care coordinator and CCSP provider, those involved in discharge planning may include, but are not limited to the following: • Family members and other informal support • DFCS • Nursing homes • Division of Mental Health/Developmental Disabilities/Addictive Diseases • Long Term Care Ombudsman • APS • Other agencies serving a client. Care Coordinators must maintain a coordinated program of discharge planning to ensure that clients have planned programs of continuing care which meet their post-discharge needs. The CCSP provider keeps the care coordinator informed of the status of a client and involves the care coordinator immediately when no satisfactory discharge plan exists. Each specific service manual contains standards for provider discharge plans.

POLICY BASICS (contd.)	**EXCEPTION**: ERS and HDM providers are not required to develop discharge plans.
PROCEDURES	Complete the following activities for discharge planning: • Develop the discharge plan during the initial assessment • Reflect discharge planning in care plans • Coordinate discharge planning in consultation with the provider's RN, other provider staff, the client's physician, other involved service agencies, and other local resources available to assist in the development and implementation of the individual's discharge plan. Consider the following factors: • Problem identification, anticipated progress • Evaluation of progress to date • Target date for discharge (difficult to assess) • Identification of alternative resources for care after discharge. Use the following procedures for discharge planning: 1. Maintain a close working relationship with the CCSP provider. This is especially important when a client discharge situation is complicated and problematic and the provider determines that no appropriate resources are available to meet client needs. 2. Coordinate a case conference with all appropriate agencies and individuals involved when a client appears to have no satisfactory discharge plan. • Participants at the case conference assure that a client is not discharged from services without appropriate care or placement. • All agencies involved share a responsibility and role in discharge planning for clients they serve or will potentially serve and are represented at the case conference.
PROCEDURES (contd.)	3. Coordinate with Mental Health care management regarding discharges for clients who have secondary mental health or

	mental retardation diagnoses. 4. Report to AAA unsuccessful attempts to develop a satisfactory discharge plan for a client. When necessary, the AAA contacts the CCSP Specialist in the Division of Aging Services for assistance. When the AAA requests assistance from the Division, the CCSP Specialist involves other appropriate state agencies to assist with resolving the problem with discharge planning. 5. Record changes on the CCP.
REFERENCES	Chapter 900, Ongoing Activities; Section 606, Provider General Manual; Appendix 100, Forms and Instructions

730 - COMPREHENSIVE CARE PLAN REVIEW

POLICY STATEMENT	Care coordinators conduct formal reviews of each CCSP client's Comprehensive Care Plan periodically according to established schedule.
POLICY BASICS	The care coordinator completes the first formal review of each CCSP client's Comprehensive Care Plan (CCP) due within 60 days of the client's admission to CCSP. After the 60-day review, care coordinators complete CCP reviews as needed but no less frequently than every four months. The care coordinator develops the care plan, involving the client in decisions to the extent possible. The CCP identifies the client's needs, goals and interventions used by the agency or person responsible for providing services. At CCP review, care coordinators use CHAT to complete the following: 1. Client Assessment Protocols (CAPs) 2. Service Order 3. Evaluation 4. Case Notes. At CCP review, care coordinators use forms to complete the following: 1. Authorization for Release of Information and Informed Consent (signature page) 2. Nutritional Screening Initiative Checklist, if applicable 3. Client Referral Form-Home Delivered Meals, if applicable. At each care plan review, the care coordinator generates the following documents from CHAT and files them in the case record: 1. CAPs, Service Order, and Evaluation
POLICY BASICS (contd.)	2. Care Review detail

	3. Case Notes, if applicable. There is no grace period beyond the CCP due date. CCP reviews completed past the four-month due date are out of compliance. If the due date for the next CCP review falls on a weekend or holiday, the care coordinator completes the four-month review before the due date. Intervening weekends or holidays do not change the CCP review due date. If a client is unavailable to complete the CCP review because of hospitalization, a visit out of town, or for another reason, care coordinator documents attempts to complete the CCP review in a timely manner. Note the reason for delay in the case notes and on the CCP, and send this information to the provider at CCP review. Complete the CCP review as soon as possible. The care coordinator may conduct CCP reviews before the required care plan review date, but completes CCP reviews no later than the scheduled due date. **EXAMPLE:** On January 03, 2004, the care coordinator admits the client to CCSP and brokers service(s). The first CCP review is due by March 03, 2004, and the second CCP review no later than July 03, 2004. Subsequent CCP reviews are due at a minimum of every four months.
PROCEDURES	Use the following procedures to complete each CCP review. 1. Prepare for the CCP review as follows: • Review the case file to become familiar with client situation at the time of the last contact • Note any item which needs updating during the CCP review • Assure that client LOC is current. 2. Telephone the client to schedule a home visit to conduct CCP review. 3. During the home visit, use CHAT to complete new CAPs, Service Order, and Evaluation. 4. Address additional triggers and evaluate goals indicated on the previous CCP to: • assure that services ordered remain appropriate • determine client need for continued CCSP services.
PROCEDURES (contd.)	

5. Review services that care giver or others provide. Identify any new services a client may be receiving from the community. Include all services on the Service Order.

6. Determine how frequently providers are delivering services indicated on the Service Order. Use the Evaluation to document whether client is satisfied with services being provided.

7. If the client receives ALS or ADH, complete the applicable Checklist. At a minimum, review the following in the clinical record:
   - RN Supervisory notes
   - Progress notes
   - Documentation of any additional services being rendered
   - Hospital admission notes, if applicable
   - Medication list and prescription label instructions.

8. Discuss with client and/or the care giver any changes in problems, interventions, and goals. Document change on the CAPs page.

9. Determine if client needs a change in services and the reason for any needed change. If a CCSP service is discontinued, changed or if a new is one needed, a reassessment may be required.

   NOTE: It is not necessary for the care coordinator to conduct a reassessment to add Home Delivered Meals, Medical Social Services, or Out-of-Home Respite Services.

10. Document verification of the client's response about continued eligibility for Medicaid. If a client is PMAO, contact DFCS to determine the status of Medicaid application and document the information in case notes.

11. Have client sign the signature page during the home visit

    NOTE: At the 60 day review, discuss with the client contents of CCSP folder not discussed at initial assessment.

PROCEDURES (contd.)

12. Telephone CCP reviews are allowable only in extenuating

circumstances, such as a care coordinator vacancy. If such an event occurs, the AAA must first obtain a temporary waiver from the Division of Aging Services, which will allow care coordinators to conduct CCP reviews by telephone for a specified period of time. In the comments section of Service Order, document the reason that the CCP review was conducted by telephone instead of in person.

13. Send a copy of newly completed CAPs and Service Order to each provider.

    NOTE: Mail these copies to providers no later than three days prior to the due date of the CCP review.

14. Update client information in CHAT and AIMS. Include changes in address, living arrangements, diagnoses, and other information.

15. Send SAFs authorizing providers to continue services.

16. Retain the new CAPs, Service Order, and Evaluation in client's case file.

    NOTE: When changes occur between reviews and reassessments and no home visit is required, complete an interim CCP. Document on the Service Order the reason a home visit was not completed.

REFERENCES

Chapter 600, Care Coordination;
Chapter 800, Reassessment;
Chapter 1100, Aging Information Management System;
Appendix 100, Forms and Instructions

740 - FOLLOW-UP ACTIVITY

POLICY STATEMENT	Care coordinators conduct follow-up activities to monitor service delivery and the client's ongoing situation and progress.
POLICY BASICS	Follow-up requires effective personal, telephone, and written communication between the care coordinator and client, the client's family and/or care givers, client's physician, service providers, and other care coordination team members. Care coordinators document all follow-up activities in the client's case notes. The CCNF, used by providers to follow up on telephone calls to the care coordinators regarding any changing in the client's situation, may be used as a tool to assist with follow-up activities. Follow-up activities are necessary to: • Confirm that quality care is provided to eligible clients • Assure that services rendered are appropriate, effective and provided as ordered on the CCPs, and as indicated on the CCNF • Identify any client complaints or concerns about services received or needed • Determine if any changes in client situation require a change in services • Identify death from the other than natural causes, serious injury or suspected abuse and report it to the appropriate authorities.
PROCEDURES	Use the following procedures for follow-up with PMAO clients to ensure that only eligible clients receive services:
PMAO Clients	1. Advise client when to make application with DFCS for Medicaid under the CCSP class of assistance. Contact DFCS to obtain Medicaid application date. 2. Contact DFCS to determine the status of the Medicaid application until Medicaid eligibility is determined.
PROCEDURES (contd.)	Use the following procedures to ensure that a client has a current LOC certification:

Level of Care	1. Establish a system for tracking LOC certifications 2. Begin the LOC redetermination at least 60 days prior to the expiration of the current LOC certification 3. After sending the LOC page and CCP Service Order to the physician, monitor its return to ensure receipt before the current LOC expires. In the case notes, document contacts with the physician, provider, family, and others regarding the return of the LOC page 4. Send DFCS a copy of the CCC and the LOC certification or recertification 5. Send copies of the new LOC certification and other reassessment documents to providers. Use the following procedures to provide follow up for a LOC denial or termination: 1. Use a CCC to notify DFCS of MAO client LOC denial or termination 2. Notify providers of client LOC denial or termination 3. If clients request, assist with appeals for denials and terminations of their LOC certifications.
Changes in Service	Use the following procedures to provide follow-up to ensure that services rendered are appropriate, effective, and provided as ordered on the CCP Service Order: 1. Document in the client's case notes all contacts with client and providers to ensure that authorized changes in service have occurred and are satisfactory. 2. Request that providers and clients contact the care coordinator regarding changes in client situation. 3. Request that providers track the number of home health visits and notify the care coordinator prior to the 50th visit.

PROCEDURES (contd)

Beginning with the 51st home health (HDS) visit, add the HDS to the SAFs.

Changes in Service

4. Respond on a timely basis to requests for changes in service units or service type on the SAF.

Maintain a central log for all complaints and concerns about service delivery. Use the following procedures to monitor service delivery:

Monitoring Service Delivery

1. Within three business days, contact the provider to advise of the complaint or concern and request a response.

2. Document the provider's verbal response on the central complaint log and, if appropriate, request written response from the provider.

3. Follow-up, as appropriate, to ensure that the complaint/issue is satisfactorily resolved .

4. Follow-up includes re-contacting the provider and sending a written request to the Area Agency on Aging for assistance when the provider does not respond or fails to satisfactorily resolve the matter. Also re-contact the client to report the disposition of the complaint/issue.

5. If attempts to resolve a problem are unsuccessful, the AAA using clear documentation furnished by the care coordination agency, may remove the provider agency from the rotation list and notify the provider agency and DHR- Division of Aging Services in writing of this determination. When removed from the rotation, the provider agency may continue services to current clients. Care coordination agencies will not refer or broker any new clients during the period the provider is removed from the rotation list. When the provider agency has corrected the deficiency, the provider must notify the AAA in writing and the AAA may reinstate the provider agency to the rotation list. The AAA will then notify the DHR- Division of Aging Services and the care coordination agency.

PROCEDURES (contd.) To ensure that identified concerns are being handled or have been

Issues in Question	resolved and that activities discussed have been initiated or completed, use the following procedures to provide follow-up: 1. Follow-up with clients, care givers, providers and others regarding the issues in question. 2. Link clients with appropriate resources to resolve problems, if needed.
Abuse/Neglect	Care coordinators and/or providers report immediately suspected mistreatment, neglect, abuse, or financial exploitation, and injuries of unknown source to Adult Protective Services (APS) Centralized Intake Unit. Follow-up on abuse reports within seven business days and document information in client record. **EXCEPTION:** For ALS clients, report abuse to the DHR Office of Regulatory Services, LTCO and APS. Report incidents of child abuse, neglect and exploitation of individuals 18 years of age or younger to DFCS Child Protective Services in the county where a client resides.
REFERENCES	Section 650, Client Protection Assurance; Section 670, Help and Deadlines; Section 660, Documentation; Section 1020, Level of Care Appeal Procedures; Section 602, Provider General Manual

742 -SERVICE SPECIFIC FOLLOW-UP ACTIVITIES

POLICY STATEMENT	Service Specific follow-up activities are conducted according to the type of services ordered.
POLICY BASICS	Provider service manuals contain detailed information about each CCSP service. Care coordinators should be familiar with information contained in provider manuals.
PROCEDURES	Report to the AAA any problems or concerns regarding a provider or facility. Assure that clients are involved in care plan and treated with respect and dignity. Become familiar with role of supervisory RN for all applicable services. Use procedures in the Chart 742.1 below when conducting follow-up and other care coordination activities related to the following specific services:

Chart 742.1 - Follow-up Activities Related to Specific Services

IF	THEN
Alternative Living Services (ALS)	Become familiar with Rules and Regulations for Personal Care Homes, Chapter 290-5-35 and the Policies and Procedures for Alternative Living Services (ALS) (CCSP). Talk with the home provider regarding client condition and care. **NOTE:** A client is permitted a trial visit from a private residence or a nursing facility to an ALS facility to determine the appropriateness of placement in the ALS home. The trial visit is limited to no more than 7 consecutive days. The ALS provider is entitled to bill for 7 consecutive days of a trial visit when recommended by the client's physician and authorized by the care coordinator. Complete the ALS checklist. A reassessment is not necessary for the trial visit. The care coordinator should complete an interim
IF (contd.)	**THEN (contd.)**

	CCP with the following information: • Add the trial visit to the CCP • Document in the comments section • Indicate the dates of the trial visit. Send the revised CCP to the ALS provider. To allow care coordinators to coordinate home health services, ALS providers inform care coordinators when clients need or receive skilled services and/or therapies. When a client residing in an ALS setting is also participating in Adult Day Care services, interview the client to determine whether participation in the Adult Day Care program is ***voluntary***. Documentation must reflect that Adult Day Care participation is the client's choice. If participation is not voluntary, coordinate steps with provider and client to resolve the conflict to client satisfaction.
Adult Day Health (ADH)	Become familiar with Policies and Procedures for ADH Services (CCSP). Visit ADH clients at least once a year at the ADH center. Speak with the provider regarding client condition and care. Complete the ADH checklist.
Home Delivered Meals (HDM)	Become familiar with Policies and Procedures for HDM (CCSP). Whenever possible, visit clients receiving HDMs at mealtime to examine the meals and discuss them with clients. At a minimum, examine the client's HDM bi-annually.
Home Delivered Services (HDS)	Become familiar with Policies and Procedures for Home Health Services and the Policies and Procedures for HDS (CCSP). **THEN (contd.)**

IF (contd.)	
	At the beginning of each calendar year, ask the Medicaid Home Health/HDS provider to track the number of home health visits that a client receives. The provider may use the CCNF to notify the care coordinator of the anticipated date when the client will receive the 50th visit.
Emergency Response System (ERS)	Become familiar with Policies and Procedures for ERS (CCSP). If the client will be out of the home for any reason, notify the provider. Unlike other service providers, the ERS provider does not routinely visit clients in their homes. If a client's home is infested with common household pests, notify the provider so they may determine if this affects the ERS.
Personal Support Services (PSS) **IF (contd.)**	Become familiar with Policies and Procedures for Personal Support Services Manual (CCSP). PSS and PSSX duties are the same. The difference between the two is the time required to perform the tasks ordered on the CCP. **NOTE:** In extenuating circumstances, PSS and PSSX may be provided on the same day, but at different time intervals. Evaluate each case closely to determine if the service is required versus desired at a different time interval. Follow-up with the client to assure: 1. PSA arrives timely and stays for the allotted time 2. All tasks are performed as outlined on the CCP, as discussed with client/ representative at assessment/reassessment. **THEN (contd.)**

	Follow- up and schedule a case conference as needed regarding missed visits and other problems.
Out-Of-Home Respite Care Services	Respite Care workers provide only **non-skilled** tasks and services that are normally provided by the clients caregiver. Respite Care is provided in a Division approved out-of-home respite care setting such as ALS, ADH or Nursing Facility. **NOTE:** PSS and Out-Of-Home Respite Care Services may be provided on the same day, if necessary. Services are ordered hourly or for a 12 hour period. The need for care giver relief must be sufficient to warrant at least three hours of RC service per visit. For hourly Respite Care there is a eight hour maximum limit. Out-of-Home Respite service units may be taken in sequence in order to allow the caregiver several consecutive days of relief. Reimbursement rates differ for hourly and 12 hour visits. Refer to Policies and Procedures for CCSP General Manual, Appendix T for reimbursement rates.

REFERENCES	Section 670, Help and Deadlines; Section 710, Brokering Services; Section 716, Authorizing Brokered Services; Chapter 1100, CCSP AIMS; Provider General Manual; Home Health Services Manual; Home Delivered Services Manual; Alternative Living Services Manual;Adult Day Health Manual; Home Delivered Meals Manual; Personal Support Services Manual; Out-of-Home Respite Care Services Manual

744 - COST SHARE (CLIENT LIABILITY)

POLICY STATEMENT	CCSP Medicaid clients may be required to pay a share of the cost of their services.
POLICY BASICS	DFCS determines CCSP Medicaid eligibility and the exact cost share amount that a client pays toward the cost of CCSP service(s). SSI Medicaid clients are not required to pay a cost share. Care coordinators discuss cost share estimates with PMAO/MAO clients during telephone screening, initial assessments, admissions, and other situations as applicable. Care coordinators provide clients with cost share brochures. Care coordinators discuss cost share payments with clients during care reviews. Clients and providers should be aware of the following information regarding cost share: • After giving a 30-day notice, providers may discharge clients who fail to pay cost share. • Providers should bill clients monthly for the cost share. Providers may avoid problems if they make efforts to collect the cost share monthly. • Providers may collect the entire cost of services from a PMAO client or they may collect an estimated cost share. Providers make adjustments in the amount collected after DFCS approves the Medicaid and determines the exact cost share amount. **NOTE:** If DFCS determines that an applicant is not eligible for Medicaid, the client is responsible for the entire cost of services delivered. CCSP Medicaid eligibility is not contingent on a client paying the cost share but on the receipt of a Medicaid waivered service. If a client's family member, neighbor or service organization chooses to pay the cost share, they should pay it directly to the provider. The amount paid by a third party to the provider for client cost share is not considered income to a client for CCSP Medicaid eligibility

PROCEDURES

The DFCS Medicaid caseworker returns the CCC or a computer-generated notice to notify the care coordinator of the exact cost share. The CCC also contains the following:

- Whether the client application for Medicaid was approved or denied
- Effective date of the approval/denial
- Client's Medicaid number.

NOTE: Review the CCC or notice carefully to determine if DFCS approved Medicaid for every month that the client has received CCSP service(s).

After receiving the information from the DFCS Medicaid caseworker, follow these procedures:

1. Enter client Medicaid Recipient number in CHAT. Use the CCSP Client Registration for AIMS form to register the client in AIMS.

2. On the SAF, assign client cost share collection to the provider(s) rendering the service with the greatest total monthly cost. Continue to assign cost share until there is no provider left to assign any collection responsibility.

   EXAMPLE: Client cost share is $400. Provider A delivers $300 in services, provider B delivers $150, and provider C delivers $27. First, assign $300 of the cost share/collection to provider A, $100 of cost share collection to provider B, and zero to provider C. Provider A collects $300 and provider B collects $100 from the client, but provider C does not collect any cost share.

3. Advise client of the amount of monthly cost share (client liability) and which provider to pay.

   NOTE: The client pays the entire cost share or the actual costs of services, whichever is less.

4. Send SAFs to providers to notify them of client's Medicaid number, cost share, and provider(s) assigned to collect the cost share.

PROCEDURES (contd.)

5. If a provider discharges a client who fails to pay the required cost

	share and another provider agrees to serve the client, arrange for the other provider to render services. **NOTE:** Inform subsequent providers that a client failed to pay the required cost share to the previous providers. 6. If no other provider agrees to deliver the service that was discontinued, but the client receives another service, send a Form 5382 to advise client of the reduction in service. Assign provider responsibility for cost share collection. 7. If the client no longer receives a service, use a Form 5382 to send a termination notice to the client. Use the CCC to notify DFCS that the client no longer receives a waivered service.
REFERENCES	Section 500, Eligibility Criteria

750 - CARE COORDINATION SUPERVISION

POLICY STATEMENT	The AAA assures that care coordinators receive supervision sufficient to implement the CCSP in accordance with established rules, regulations, policies and procedures.
PROCEDURES	Care coordination supervision includes the following activities: 1. Supervisory reviews of 10% of the monthly case record activities completed by each care coordinator. These activities include but are not limited to the following: • Assessments • Reassessments • Care reviews. When completing case record reviews, give special attention to the following documentation: • Completed LOC page and LOC criteria chart • CCP, especially triggers, CAPs, interventions, and triage level • MDS-HC, especially documentation of skin, weight, medication compliance • Case notes and follow-up activities • Completed Comprehensive Care Plans. **NOTE:** The care coordinator supervisor sends a monthly summary report of the supervisory reviews to the AAA director. 2. Review of all terminations 3. Regularly scheduled supervisory conferences to discuss performances and annual performance appraisals 4. Regularly scheduled training sessions 5. Case conferences 6. The use of reports generated by CHAT and AIMS to keep abreast of the care coordinator's work load and activities.
REFERENCES	Chapter 600, Care Coordination; Chapter 700, Care Management; Chapter 800, Reassessment; Chapter 900, Ongoing Activities

760 - CARE COORDINATION MONITORING

POLICY STATEMENT	The Division of Aging Services, AAAs, and care coordination agencies monitor CCSP program activities according to the terms of the 1915c Home and Community Based Waiver and all applicable DHR policies and procedures.
POLICY BASICS	The following activities require monitoring: • Compliance with CCSP regulations, policies, and procedures • Lead Agency programmatic and financial reports • Case file organization • Case notes documentation • Complaint logs • Follow-up • Supervision
PROCEDURES	The Division of Aging Services will monitor annually a minimum of five percent of the cases statewide monitored by the AAAs. This monitoring will be conducted by the CCSP Section or the Planning and Evaluation (P&E) Section. In addition, the P&E Section, Division of Aging Services, will monitor the AAAs and care coordination agencies in accordance with priorities set, scheduled and prescribed by the DAS Quality Assurance Team with DAS Leadership Team approval. The AAAs will monitor care coordination activities at a minimum twice a year. As part of this process the AAAs will monitor five percent of the annual case records of the care coordination agency/unit, using a monitoring tool developed by the DAS.
REFERENCES	Chapter 300, Administrative Organization; Chapter 700, Care Management; Appendix 100, Monitoring Tool Appendix 300, Job Descriptions