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STATE OF ALABAMA  
INDEPENDENT LIVING  
WAIVER

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POLICY AND  
PROCEDURE MANUAL  
2016



OCTOBER 1, 2016

ALABAMA DEPARTMENT OF REHABILITATION SERVICES  
602 S. Lawrence St., Montgomery, AL 36104

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## **FORWARD**

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

# Chapter 1

## Program Administration

### **A. CENTERS FOR MEDICARE AND MEDICAID SERVICES**

1. CMS is a federal agency within the Department of Health and Human Services that is responsible for the oversight of administering Medicaid and Medicare programs. The central office is located in Baltimore, Maryland. States are divided into regions. The state of Alabama is located in Region IV.
2. Any new waiver requests are submitted to the central and regional offices for approval. If an HCBS waiver requires an amendment to its originally approved contents, the submission is sent to the regional office for approval. A regional contact person for the home and community based waivers is assigned. CMS staff is responsible for making sure the waiver is implemented and administered according to the waiver document and all assurances are being met. The CMS 372 report is submitted on an annual basis and is used to determine whether or not the program is meeting the clients' health care needs; that the clients' health and safety is being safeguarded and that the program is cost effective. CMS also conducts compliance reviews. The review schedule and activities are coordinated with the AMA Long Term Care Division. During the review, the representatives interview waiver participants, providers and State Medicaid staff who perform duties applicable to the operation and monitoring of the waiver. These are usually done during the year prior to the expiration of the waiver.

### **B. ALABAMA MEDICAID PROGRAM**

1. Medicaid was created in 1965 by Congress along with a sound-alike sister program, Medicare. Medicare is a health insurance program primarily for elderly persons, regardless of income. It is financed through Social Security taxes and premiums. Medicaid is jointly financed by the state and federal governments and is designed to provide health care to individuals with low income. Medicaid started in Alabama in 1970 as a Department of Public Health program. In 1977, the Medical Services Administration was made an independent state agency. In 1981, the agency was renamed the Alabama Medicaid Agency.
2. The AMA administers the state Medicaid Program as directed by the governor. The head of the agency is the Commissioner, who serves at the pleasure of the governor. Medicaid also serves as the administering agency in the waiver programs. The Long Term Care (LTC) Division in collaborative effort with other state agencies, is responsible for administrative oversight of the waiver. A list of contact persons in

the LTC Division is included in the Appendix A or may be viewed on the Medicaid website ([www.medicaid.alabama.gov](http://www.medicaid.alabama.gov)).

3. AMA provides services through the Medicaid State Plan that are separate from waiver services. The services covered under the State Plan are included in Appendix A or may be viewed on the Medicaid website ([www.medicaid.alabama.gov](http://www.medicaid.alabama.gov)).

### **C. FISCAL AGENT**

1. The AMA contracts with a fiscal agent to process and pay all claims submitted by providers of medical care, services, and equipment authorized under the Title XIX State Plan.
2. The present fiscal agent is HP Enterprise Service, P. O. Box 244035, Montgomery, 36124-04025. The toll free number for provider inquiries is 1-800-688-7989. HP prepares and distributes provider billing manuals upon request.
3. HP is responsible for enrolling providers in the Medicaid program and for maintaining provider information in the Alabama Medicaid Management Information System (AMMIS). They are also responsible for preparing and distributing provider billing manuals to providers of Medicaid Services for guidance in filing and preparing claims. The fiscal agent's Provider Inquiry Unit, through provider representatives is available for technical assistance and education to Medicaid providers of service. Providers with questions about claims should contact them directly for assistance. Please see the Medicaid website, ([www.medicaid.alabama.gov](http://www.medicaid.alabama.gov)), for contact information.
4. Unsolved problems or provider dissatisfaction with the response of the fiscal agent should be directed to Alabama Medicaid Agency, P. O. Box 5624, Montgomery, Al 36103-5624; Attention: LTC/Consumer Service/Claims Administration. The Alabama Medicaid Agency (AMA) with the oversight of The Centers for Medicare and Medicaid Services (CMS) is responsible for administration of the home and community-based service (HCBS) waivers.

### **D. ALABAMA DEPARTMENT OF REHABILITATION SERVICES' MISSION STATEMENT**

The mission of the Alabama Department of Rehabilitation Services (ADRS) is to enable Alabama's children and adults with disabilities to achieve their maximum potential. This mission is reflective of the broad nature of the department which serves

children with disabilities, adults who have a physical or mental impairment which constitutes or results in a substantial impediment to employment, and individuals, who because of the severity of their disability(ies), may not at the present time have vocational potential.

The intent of the SAIL Medicaid Waiver is to enhance the quality of life by providing services to individuals with severe disabilities. The waiver services will allow the individuals to achieve and maintain their maximum independence in their home environments.

#### **E. ADMINISTRATION OF SERVICES**

The Alabama Medicaid Agency is the administering agency for SAIL Waiver program and the Alabama Department of Rehabilitation Services (ADRS) is the operating agency. As the operating agency, ADRS is responsible for the daily management and operation of the program. In the daily management of the program, ADRS focuses on client outcomes such as improving client care, protecting client health and welfare, offering the client free choice of providers for waiver services and waiver service staff. ADRS management responsibilities also include assuring all direct service providers meet the required provider qualifications. ADRS authorizes and provides all services either directly or by contractual agreements with other service providers. The SAIL Waiver program is assigned the identification number: 800000001 or National Provider Identification Number of 1053489534.

#### **F. GENERAL INFORMATION**

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

#### **G. HCBS SETTING ASSURANCES**

SAIL Waiver services shall be provided according to the Home and Community-Based Services Settings Final Rule (CMS 2249-F/2296-F) as follows:

All home and community based setting shall meet the following qualifications:

- The setting is integrated in and supports full access to the greater community;
- Is selected by the individual from among setting options;
- Ensures individual rights of privacy, dignity and respect, and freedom from coercion and restraint;
- Optimizes autonomy and independence in making life choices; and
- Facilitates choice regarding services and who provides them.

In the event SAIL Waiver services are provided to an individual living in a provider-owned or controlled home or a community-based residential setting, the following qualifications shall be met:

- The individual has a lease or other legally enforceable agreement providing similar protections;
- The individual has privacy in her/his unit including lockable doors, choice of roommates and freedom to furnish or decorate the unit;
- The individual controls his/her own schedule including access to food at any time;
- The individual can have visitors at any time; and
- The setting is physically accessible.

Any modification to requirements for provider-owned/controlled homes or community-based residential settings must be supported by a specific assessed need and justified in the person-centered service plan.

SAIL Waiver services will not be provided in nursing facilities, institutions for mental disease, intermediate care facilities for individuals with intellectual disabilities, or hospitals. SAIL Waiver services will not be provided in publicly or privately-owned facilities that provide inpatient treatment; on the grounds of, or immediately adjacent to, a public institution; or that have the effect of isolating individuals receiving Medicaid-funded HCBS from the broader community of individuals not receiving Medicaid-funded HCBS.

## **H. STATEWIDE AVAILABILITY**

Alabama Medicaid Agency has provided SAIL with the number of slots approved for the provision of services. The exact number of approved waiver slots for each year will be listed in the approved waiver document. At this time SAIL has 660 approved slots.

A waiver slots cannot be refilled during the waiver year except by the participant that vacated the slot. Waiver slots vacated by Waiver-to-Waiver transfers cannot be refilled until the beginning of the next Waiver year. Any slot vacated and not refilled by its corresponding participant will become available on the new waiver year. A Waiver year is April 1 to March 31.

## **I. PHILOSOPHY OF LONG TERM CARE**

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

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

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

## Chapter 2

# Home and Community-Based Waivers

Home and Community-Based Services is one of the most popular Medicaid options available to states. Authority to grant waivers was provided by Section 2176 of the Omnibus Budget Reconciliation Act of 1981, which added Section 1915(c) to the Social Security Act. Under Section 1915(c) of the Social Security Act, the Centers for Medicare and Medicaid Services waived certain statutory requirements to allow a state to cover a broad array of home and community-based services as an alternative to institutionalization. In other words, the Waiver “waives” existing rules of the Social Security Act. It is beneficial as it allows the client to receive services in the home. It gives the client a choice between institutional care and waiver services. The waivers must define a distinct population, define a level of care, and be cost-effective in preventing institutionalization. Under this statutory authority, waivers are granted for an initial term of three years. Upon the state’s request, the waiver may be renewed for an additional five-year period.

The State develops the waiver proposal and submits it to CMS for approval. The state of Alabama has developed seven HCBS waivers that provide alternatives to institutionalization for some Medicaid recipients. The waiver programs are aimed at helping recipients receive extra services not ordinarily covered by Medicaid in this state. HCBS programs serve the elderly and disabled, intellectually disabled, and adults with physical disabilities with specific medical diagnoses. The programs provide quality and cost-effective services to individuals who are at risk of institutional care. Alabama’s HCBS Waivers are:

- Elderly and Disabled Waiver (EDW)
- Intellectual Disabilities (IDW)
- State of Alabama Independent Living Waiver (SAIL)
- Living at Home Waiver (LHW)
- HIV/AIDS (5230) Waiver,
- Technology Assisted Waiver for Adults (TAW)
- Assisted Community Transition Waiver (ACT)

*The information in this manual will be specific to the State of Alabama Independent Living (SAIL) Waiver.*

### **A. SAIL WAIVER**

The State of Alabama Independent Living Waiver (SAIL) allows individuals with specific diagnoses and related illnesses who are at risk for nursing home placement to remain in the community as long as their health and safety is not at risk. The waiver

seeks to provide quality, supportive, and cost effective services to individuals at risk of institutional care. This waiver provides specialized services in addition to the regular State Plan Medicaid Services. Such services are based on individual need. Those with the greatest need should be given priority on a first come, first serve basis. All efforts should be exhausted to screen referrals and network with community resources rather than keeping individuals on a long-term waiting list. All appropriate referrals should be made to other waivers. There should be no waiting list for the SAIL waiver as long as there are slots available. Other Waivers are available based on qualifications set by Medicaid.

## **B. WAIVER REQUIREMENTS**

The SAIL waiver only provides services to those residents that are within the State of Alabama and receiving those services within the State of Alabama. SAIL must be able to make the following assurances:

- 1. Health & Welfare:** The State assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:
  - a. Adequate standards for all types of providers that provide services under this waiver;
  - b. Assurance that the standards of any State licensure or certification requirements are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements are met on the date that the services are furnished; and,
  - c. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable State standards for board and care facilities.
  
- 2. Financial Accountability.** The State assures financial accountability for funds expended for home and community- based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver.
  
- 3. Evaluation of Need:** The State assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community- based services under this waiver.

**4. Choice of Alternatives:** The State assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group, the individual (or, legal representative, if applicable) is:

- a. Informed of any feasible alternatives under the waiver; and, enrollment in only one waiver at a time is allowed; and
- b. Given the choice of either institutional or home and community-based waiver services.

### **C. TARGET POPULATION**

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

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

### **D. SERVICES**

SAIL waiver services must be provided in accordance with a properly completed individualized plan of care that is participant-centered. Services may include any or all of the following:

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

The SAIL Waiver program has the right to limit the number of Medicaid Waiver participants they are able to serve, based on the approved waiver document. And they are able to select applicants/participants based on the target population that the waiver serves. However, the waiver program and service providers may not discriminate in the selection of the participants they serve.

# Chapter 3

## Eligibility Criteria

### A. DETERMINATION PROCESS

The Alabama Medicaid Agency, based on information supplied by Case Manager (See Application Process) determines eligibility.

### B. VERIFYING ELIGIBILITY

In order to receive services through the Waiver program a participant apply and be approved for services. The participant must have the following in order to apply for services:

1. A qualifying physical disability that places them at risk for nursing home placement.
2. A desire and support system to remain in the community.
3. Ability to be maintained in a healthy and secure manner in their home.
4. Must reside within the State of Alabama.
5. Receive the services within the State of Alabama.
6. Meet the financial guidelines.

In order to be qualified for application to the waiver program the applicant should have applied to the Social Security for disability determination. They should have been determined disabled and be potentially eligible for SSD and/or SSI and Medicaid. If they have not applied then a Medical Determination must be sent to Medicaid.

If an applicant is not currently receiving Supplemental Security Income (SSI) or Social Security Disability (SSDI) and it appears he/she may qualify, the applicant should be referred to the Social Security Administration, unless a recent application has been made. Both Medical and Financial Eligibility is determined by the Alabama Medicaid Agency.

If a participant has received an approval for SSDI but is not presently eligible for Medicaid or SSI and is seeking Medicaid sponsorship in a long-term care Waiver Program, once the medical determination has been completed then the MED 204 financial application form and the HCBS slot conformation form must be submitted to Medicaid District Office.

## **C. MEDICAL ELIGIBILITY**

All applicants and participants must meet the Nursing Facility Level of Care Criteria. These individuals are diagnosed with physical disabilities not associated with the process of aging and with onset of the disability prior to age 60. The target population to provide waiver services will be persons having these diagnoses: quadriplegia, traumatic brain injury, amyotrophic lateral sclerosis, multiple sclerosis, muscular dystrophy, spinal muscular atrophy, severe cerebral palsy, stroke and other substantial neurological impairments, severely debilitating diseases or rare genetic diseases, e.g. Lesch-Nehan Syndrome.

## **D. FINANCIAL ELGIBILITY**

If the applicant has been deemed disabled by the Social Security Administration (SSA) then they are presumed eligible.

If they receive Social Security Insurance and Medicaid as a result of the determination by SSA, then financial eligibility has been established and Medical Criteria must then be met.

If they receive Social Security Disability and do not have Medicaid then a financial application must be completed (Form 204) and submitted to the local district Medicaid Office. The financially eligible categories are 300% and the Institutional deeming /spousal impoverish rule. Once the medical determination is made by the SAIL nurse reviewer then the case manager will send the financial application and a slot confirmation form to the local Medicaid district office.

### **1. Special Income Level Recipients**

#### **a. 300%**

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

#### **b. Institutional Deeming Process / Spousal Impoverishment**

The Institutional Deeming process may be used to disregard the income of a potential waiver recipient's parent or spouse. When considering the parent or spousal income, it may

appear that the applicant would not qualify financially for waiver. Institutional Deeming allows for the application to be made to Medicaid and requests that the other income be disregarded.

Under federal law, spouses may be covered under the Spousal Impoverishment rule. What this means is Medicaid is required to do an assessment of the resources belonging to the applicant, assets belonging to their spouse, and any jointly owned assets of the couple. The date of assessment will be the date Medicaid receives the application.

The first \$25,000.00 of resources are protected for the spouse who is not the applicant. The applicant's resource limit is still \$2,000.00 as of the first moment of the first day of the month. If the combined countable resources exceed \$27,000.00, then the applicant will not be eligible because they will have excess resources.

#### **E. PARTICIPANT IDENTIFICATION**

Those applicants that currently have Medicaid as a result of Social Security SSI, have a Medicaid card with a number. Upon approval for the waiver, all other applicants/participants are issued a Medicaid card with a number. The Medicaid ID number consists of 13 digits. This Medicaid number that is issued will be their number for lifetime.

#### **F. INELIGIBLE FOR ADMISSION INTO THE WAIVER PROGRAM**

There are individuals that may apply for the waiver that are ineligible for admission to the waiver program. It has been determined that the SAIL waiver services cannot be delivered to individuals in the following circumstances:

- Residing in a domiciliary (Assisted Living Facility ALF).
- Residing in a hospital, nursing facility/swing bed or other acute care facility.
- Receiving services through any other approved and implemented HCBS Waiver Program.
- Primary diagnosis of mental illness and/or mental retardation.
- Residing in a boarding home (Medicaid sponsored).
- Choosing nursing facility care.
- Residents of another state.
- Alabama resident living in another state.
- Health and safety is at risk in the community as determined by the Alabama Medicaid Agency and/or the Administering State Agency.
- Medicaid eligibility blocked due to transfer of assets.
- The Medicaid Agency and/or Administering State Agency determine if there is reasonable expectation that Waiver Services would be more expensive than institutional care.

## **G. DENIAL OF ADMISSION INTO THE WAIVER PROGRAM**

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

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

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

## **H. CONFIDENTIALITY AND HIPPA**

All applicant and participant information acquired shall remain the property of the SAIL Waiver program and ADRS. This information will only be used and released for purposes directly related to the administration of SAIL Waiver Program. ADRS staff will only use the applicants/participants personal health information when doing their jobs. When health information is shared with other agencies or organizations, ADRS requires the other agencies and organizations to safeguard the applicants/participants health information. Use and release of personal information shall conform to applicable State and Federal laws and regulations.

All applicants, participants, or participant's representatives are to be informed of the confidentiality of records.

Release of information must be by written consent of the participant or authorized representative to include:

- The nature of the information to be released;
- Designation of the parties to whom the information may be released;
- The specific purpose for which the released information may be used;
- Designation of the agency or person authorized to disclose the information;

Date of initiation and termination of consent.

To the extent that another agency or organization demonstrates that information is necessary, and with written consent of the SAIL Waiver participant or their representative, the SAIL Waiver program may release information to the requesting agency or organization.

SAIL may share information with other government agencies or organizations that are providing benefits or services when the information is necessary in order for the applicant/participant to receive those benefits or services.

Information may also be shared between divisions within ADRS (Early Intervention, Children's Rehabilitation Service, and Vocational Rehabilitation) in order to determine the applicants/participants eligibility for other benefits or services provided by the department.

SAIL may disclose health information to the appropriate agencies for public health activities for disease control and prevention, problems with medical products or medications and also victims of abuse, neglect or domestic violence as required by law.

SAIL may disclose specific health information to authorized health oversight agencies responsible for the Medicaid program, Maternal and Child Health Bureau and the Department of Health and Human Services, Office of Civil Rights, Judicial and administrative hearings

SAIL may disclose specific health information in judicial and administrative proceedings as required by Law.

SAIL may disclose specific health information for law enforcement purposes as required by law.

Information or documentation in a participants file may not be released when the information is from a third party and not produced by ADRS/SAIL. Information obtained from other organizations or agencies may be released only under the conditions established by the outside agency, organization, or provider.

Information or documentation may be withheld when the SAIL Waiver Staff believes medical, psychological or other information may be harmful to the individual, the information may not be released to the individual, but may be provided to their representative, treating physician, or licensed or certified psychologist, or requesting agent.

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

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

that records are court ordered or subpoenaed, the SAIL supervisor is immediately notified, as well as the ADRS Legal Counsel.

*If SAIL staff receives a court order or subpoena, that staff person must immediately notify their supervisory via email and phone call for instructions and direction.*

# Chapter 4

## Application Process

### **A. REFERRAL PROCESS**

The application process begins with a referral on the person seeking entry onto the waiver. A potential applicant may refer themselves for services at any SAIL Waiver office located closest to the county in which they resides. The SAIL Waiver offices may also receive referrals from family members, interested neighbors or friends, physicians, hospitals, nursing homes, or staff of a public or private agency.

This referral process includes personal information, current diagnosis, current benefit status, functional abilities to perform ADLs, additional resources and any services currently provided to the individual in the home. Based on the information gleaned during the referral interview, the person is either told that they do not qualify for the SAIL waiver based on the information received during the referral process and placed on a list for the application process or they are placed on a referral list for further assessment for potential entry onto the waiver program. Further assessment may be needed to determine if SAIL is an appropriate referral or if another waiver is more appropriate.

If for any reason an application cannot be taken at the time of referral, then the applicant should be placed on the referral wait list under the SAIL Director's name. A referral to the Independent Living Specialist should be made so that services needed can be assessed and provided until a vacancy occurs on a waiver caseload. The Staff receiving the referral call should also explore the possibility of referrals to other waiver or community programs with the individual.

Out-of-state referrals (applicants) must intend to relocate within the geographic area. They must reside in the State of Alabama for at least 30 days and have a primary documented residence in the State of Alabama. The SAIL Waiver employee cannot travel outside the State of Alabama to interview a prospective participant.

If a referral is selected off the referral list and the referral cannot be reached due to a faulty telephone number, a letter will be sent to the person at their last known address stating the reason for the contact and that he/she should contact the local office within 14 days of the date of the letter for screening purposes. If the person does not respond, they will no longer be considered for application to the Waiver. If the applicant is unreachable and has been removed from the list, they may request to be replaced on the list with additional and current information.

In order for an individual to be eligible for an application and determined to need waiver services and referred for an application an individual must require:

1. The provision of at least one waiver service, as documented in the service plan.
2. The provision of waiver services at least monthly or, if the need for services is less than monthly.
3. The participant requires regular monthly monitoring which must be documented in the service plan.

*A MSIQ must be pulled prior to taking an application to verify eligibility.*

See Appendix for How to read the MSIQ.

## **B. PRE-ADMISSION REVIEW**

Once the applicant is up for application, the case manager will perform a pre-admission review of the referral. If the referral is older than twenty (30) working days at the time the referral becomes eligible for application, the case manager must contact (call) the applicant/responsible party to confirm and verify the information obtained in the referral assessment. All information should be verified with the applicant prior to scheduling the home visit. The case manager should specifically inquire if the applicant is receiving any services from any other programs, including other waivers. An MSIQ must be pulled for verification of eligibility and programs.

## **C. TAKING AN APPLICATION**

Once the case manager determines that the referral applicant meets the criteria for admission, and there is an available slot, the case manager should complete an application on the referral. The application must be signed by the applicant or responsible caregiver.

Approved signatures include:

The full legal name of the applicant/participant. No nick names. A participant may sign the Admission and Evaluation Form with an "X" followed by a statement --Mark of recipient's name-- and the mark must be witnessed. If the applicant or participant signs with an "X", then the signature must be witnessed by the case manager or a family member or significant other. If an applicant/participant is physically impaired to the extent he or she is unable to sign for him or herself, the legal representative/ responsible caregiver may sign the form. The signature must be in the following format:

Caregiver first name and last name for Applicant first name and last name.

Example: Ima Hurt for Ura Hurt

Or

Applicant first name and last name by Caregiver first name and last name.  
Ura Hurt by Ima Hurt

It is the case manager's responsibility to assure that the documents are signed in the correct and legal manner and dated with the accurate date. It must be clearly documented as to why participant did not sign and the person who signed must be identified in the case narrative.

Applications are taken during the initial home visit. All application documents must be completed accurately and signed during the initial home visit with the applicant.

The initial application visit must be performed in the home environment where the person lives and where the services will be rendered. There must be a reasonable indication of need for services. At least one service must be needed in order to continue the application. The case manager must do a thorough assessment in order to present a clear picture of the applicant's medical status, functional abilities, and home environment as needed to support the need for services.

The case manager is responsible for assessing whether the participant is free from coercion or restraint, and is not being restricted by others or the environment from fully engaging in service provision.

As part of the application the Case Manager must explain the intent of the program. They must thoroughly go over each part of the application forms and documents. They must involve the applicant/caregiver to the greatest extent possible in the assessment process. They must explain all available services to the applicant and the family. After the explanation is complete, then waiver services are individualized to best meet the needs of the applicant. If the SAIL waiver is not appropriate or is unable to meet the needs of the participant and another waiver program would more appropriate. Then the application will end and a referral will be made to the more appropriate waiver program.

Every effort must be made to include the applicant in the interview and planning process. When an applicant is physically or cognitively unable to participate in an interview, a relative, guardian or primary caregiver can be interviewed for completion of the assessment. All forms must be completed thoroughly and dated on day of the visit. The case manager must have a thorough knowledge of the forms and knowledge about their meaning and why SAIL has them as part of the application process. These application forms will remain as part of the case record.

This application includes the following forms:

The Home and Community Based SAIL Waiver Admission and Evaluation  
Medical Supply List  
Medical Supply Participant Understanding  
Waiver Responsibilities  
Complaint and Grievance Guide  
Confidentiality Release  
DHR notice  
Email, Text and Fax Form  
Notice of Privacy Practices  
Voter Registration  
Participant Choice Documentation  
Vendor Choice Form  
Person Centered Planning  
Form 204 Financial Application  
Slot Confirmation form

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

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

*All application forms must be signed by the participant in Blue Ink.*

## **1. THE HCBS EVALUATION**

Home and Community Based SAIL Waiver Admission and Evaluation. This form is to be completed at initial intake, redetermination, and readmission. The HCBS form must be in the approved format and on YELLOW paper. It must clearly identify the case manager with their appropriate identifying information.

SAIL Waiver recipients must meet Alabama's nursing facility level of care. Waiver applicants for whom there is a reasonable indication that services may be needed in the future are provided an individual Level of Care (LOC) evaluation. The tool used to determine the NF LOC is the Alabama Home and Community Based Services Program Assessment (HCBS-1) form.

The case manager performs a thorough assessment of the applicant/participant's living situation, their ability to perform activities of daily living, available community resources, support from family/others and develops a plan of care to address any gaps which place the applicant/participant at risk for nursing home placement.

The case manager is responsible for accurately completing the HCBS (all three pages). And, is responsible for obtaining the most reliable and accurate information available at no cost to SAIL.

The form should not be completed by the applicant/participant. After completion, the form is then sent to the person's physician for signatures. Do NOT send a blank HCBS form to the physician. A blank HCBS form should NEVER be sent to medical personnel for them to complete. It is to be completed by the case manager with as much information as can be gathered prior to sending it for medical certification.

Medical certification is obtained from a qualified medical provider. Information gathered by the case manager and the qualified medical provider is forwarded to the Nurse Reviewer for a Level of Care determination.

A Level of Care determination for an applicant/recipient is processed based upon information contained on the HCBS-1 assessment as well as qualified medical provider's progress notes and/or hospital records as needed or requested by the nurse reviewer. 6 months of medical records are required for new admissions, these medical records must support the qualifying diagnosis. Medical records may be requested during a redetermination.

The Nurse Reviewers evaluate the application to make sure it is complete, supports the need for waiver services, and establishes that risk of nursing home placement and that medical criteria are met before level of care is approved. Consideration is also given to the functional limitation of the individual, medical diagnosis, support systems in place and any other factors which put the individual at risk for institutionalization.

New admissions and readmissions must meet two of the criteria listed in A-K. Supporting documentation must be submitted with the application.

In order to process the HCBS form:

The signature of the applicant or responsible party must be in blue ink.

The responsible party must have signed in the approved manner.

Both the applicant or responsible party and the qualified medical provider's signatures must be original.

Only the original HCBS will be accepted. Faxed copies will not be accepted for medical determination.

a. **HSBC page 1**

The participant's current diagnosis and medications are included on this page 1. This page must be signed by the applicant or responsible party at the time of initial home visit to ensure that the applicant, is involved in planning their long term care needs.

**Freedom of Choice**

**Informed of feasible alternatives under the waiver.**

The applicant/participant signs showing they have been given a choice between community and nursing facility care, this is "Freedom of Choice". By signing this section, the participant is choosing community based SAIL waiver in lieu of nursing home Medicaid and placement. It also provides authorization for SAIL to share and gather information with the primary medical provider.

As provided in 42 CFR §441.302(d), when an individual is determined to be likely to require a level of care for this waiver, the individual or his or her legal representative is:

- A. Informed of any feasible alternatives under the waiver; and
- B. Given the choice of either institutional or home and community-based services.

As part of the assessment and service coordination visit, clients and/or responsible parties are provided with adequate verbal information to make an informed decision as to where the client's care will be received. Service coordination addresses problems and feasible solutions. It also includes an exploration of all the resources utilized by the client, both formal and informal, as well as those waiver services which may be available to meet

the client's needs and those needs which cannot be met. Participants and/or their representative are given as much information as possible to allow them to make an informed choice based upon their individual and personal preferences without putting their health and safety at risk.

**Given the choice of either institutional or home and community based services.**

Information is also provided in writing. Each waiver client must make a written choice for either institutional or community care by signing the freedom of choice statement on the Admission and Evaluation Data form (HCBS-1, page 3), which serves as documentation of the individual's choice, and which will remain in effect until such time as the client changes his/her choice. The only exception to making a written choice is when the client is not capable of signing the form. In such cases, services are not denied if a written choice cannot be obtained. The reason(s) for absence of a signed choice must be carefully documented by the case manager. A responsible party should be encouraged to assume responsibility for working with the case manager in arranging for an appropriate plan of care. This may include the responsible party signing the forms.

**State Recovery Program**

The State Recovery Program was established under federal law. It requires the Alabama Medicaid Agency to recover the costs paid by the Agency from the estates of deceased Medicaid recipients.

*SEE Appendix: STATE RECOVERY PROGRAM, WHAT IS THAT????*

All three acknowledgements must be signed by the participant or the responsible caregiver. If the applicant/participant or caregiver refuse to sign any of the three sections, the application will be terminated. A denial letter will be sent to the applicant/participant.

**BOTH APPLICANT (CAREGIVER) AND MEDICAL PROVIDER'S SIGNATURE ON THE HCBS MUST BE ORIGINALS. Faxed or emailed copies are not allowed.**

**Qualified Medical Provider**

The Alabama Medicaid Agency prefers the signature of the Physician on the HCBS Waiver Certification/Recertification Form. However, they will accept signatures from the professionals listed below:

Certified Physician Assistants (PAs) and Certified Registered Nurse Practitioners (CRNPs) who are legally authorized to furnish services and who render services under the supervision of an employing physician.

**ICD code**

The primary QUALIFYING disability and secondary condition(s) must be selected. It must include the ICD-10 code on the HCBS form. The code is to be written beside the qualifying and secondary disabilities.

b. **HCBS page 2**

The applicant/participant must meet two of the criteria A through K both for initial application and redetermination. The criteria should reflect the individual's capabilities on an ongoing basis and not isolated, exceptional, or infrequent limitations of function in a generally independent individual who is able to function with minimal supervision or assistance.

All information must be completed in its entirety in compliance with Alabama Medicaid guidelines. Those application worksheets with incomplete information will be loaded into the case management system SMILE. If the information is not complete or inaccurate it may not allow the SMILE case management system to transfer the HCBS-1 for processing.

"Other Agencies providing services in home within the last three months" should be completed not only during the initial applications, but on redeterminations as well. Examples of providers includes: Home Health agencies, Hospice care, Physicians, ADRS (VR), SAIL (IL), or any other community resource. These other agencies will also be listed on the Plan of Care under "NON-WAIVER SERVICES".

Once the entire case is documented in SMILE, the case manager will electronically submit the case to the Nurse for determination. The case manager will scan and email the original to the Nurse for her to review and correct or approve.

c. **HCBS page 3**

All prescribed medications must be listed on page 3 with the strength, dosage, and route of administration. For each medication there must be a diagnosis that the medication refers to.

## **2. MEDICAL SUPPLY LIST AND PARTICIPANT UNDERSTANDING**

The Medical Supply List and the Medical Supply Participant Understanding must be completed at initial intake, redetermination, and readmission.

Medical supplies include devices, controls and/or appliances, specified in the Plan of Care, which enable individuals to increase their ability to perform activities of daily living, to maintain health and safety in the home environment, and to perceive, control, or communicate with the environment in which they live. All waiver medical supplies must be prescribed by a physician, be medically necessary and be specified in the Plan of Care.

“Medically necessary” means that the service is directed toward the maintenance, improvement, or protection of health or toward the diagnosis and treatment of illness or disability. The OA records on each recipient must substantiate the need for services, must include all findings and information supporting medical necessity, and must detail all treatment provided.

Supplies must be medically necessary for participant’s qualifying diagnosis/disability. They include Antibiotic Cream, Adult Diapers, Adult Wipes, Cara Form, Cara Klenz, Derma spray, Sterile/Distilled Water, Duoderm, Enemas, Liquid Nutritional Supplements, Glycerin Swabs, Gloves, Laxatives/Stool Softeners/Suppositories, Linen Savers, Periwash, Sterile Q-tips, Skin Protectives, Skin Bond, Skin Prep Spray, Soft Wick Sponges, Washable Chux, and Wound Care Items.

Case managers will determine whether the medical supply is medically necessary and promotes health and safety. The medical supply should be of medical grade. All items shall meet applicable standards of manufacture, design and installation.

Medical supplies do not include over-the-counter personal care items such as Soap/Body wash, Tooth brushes, Tooth Paste, Mouthwash, Vaseline, Alcohol, Peroxide, Witch-hazel, Lotions, Eye drops, Douche, Deodorant, Shavers, Shave cream, Vitamins, Aspirin, Band-Aids, Q-tips, Thermometers, Hand sanitizer, Decongestants, Cough Syrup, Sports creams/Biofreeze and other Over-counter Medications

The case manager will explain to the applicant/participant that all items reimbursed with waiver funds shall be in addition to any medical supplies furnished under the State Plan. Any supplies that are covered under the State DME program cannot be billed as a waiver item. It must be billed through the State DME procedure codes. Such items include: Betadine, Karayo Powder, Gloves (2 boxes), Catheters/Catheter trays, Needles/Syringes, Gauze (all), Tape (medical), Drainage Bags/Leg Bags, Ostomy Supplies, Wound Care Items

Waiver will exclude any medical supply that is not of direct medical or remedial benefit to the individual.

Medical supplies can be authorized at a maximum of 150.00 per month. And it is limited to \$1800.00 per recipient per year.

### **3. WAIVER RESPONSIBILITIES**

The Waiver Responsibilities must be completed at initial intake, redetermination, and readmission.

Each applicant/participant has responsibilities that they must fulfill in order to participate in the SAIL waiver program. The applicant/participant has the responsibility to follow their medical plan of care with their medical provider. This includes yearly visits to their medical provider, so that the provider is informed of their medical condition.

The applicant/participant is responsible for maintaining contact with their counselor, case manager or nurse. They are responsible for notifying SAIL staff immediately of any changes of address or phone number.

Since services cannot be rendered if the participant is in a hospital or nursing home, the participant or caregiver is responsible for notifying SAIL immediately if the participant is admitted to the hospital or nursing home.

If the participant leaves the State of Alabama for a week. They must notify SAIL immediately. Services cannot be rendered in another State.

The applicant/participant is responsible for notifying SAIL of any changes in Social Security, Retirement, Medicare, Medicaid or private insurance, as soon as they receive notification.

The applicant/participant has been provided the Medical supply form to sign as part of the application. The applicant/participant by signing has acknowledged they have received the information and agrees to only order approved medical supplies.

The case manager must inform the client that the services must be pre-approved and pre-authorized by SAIL. Under no circumstance should a participant be reimbursed for a service.

The applicant/participant is responsible for being available for a monthly face-to-face visit in their home. If they refuse a scheduled home visit or miss a scheduled home visit. Services are placed on hold immediately until another home visit can be made at the case manager's convenience. Applicant/participant must be informed that failure to allow the face-to-face will result in services being put on hold and may result in termination of the program.

The applicant/participant is responsible for identifying and having a caregiver. The participant must have an emergency plan in place to ensure care in the event that waiver services are interrupted. This person is someone who is willing and able to care for the participant when required.

#### **4. COMPLAINT AND GRIEVANCE GUIDE**

The Complaint and Grievance Guide must be completed at initial intake, redetermination, and readmission.

The Alabama Medicaid Agency and the Alabama Department of Rehabilitation Services want to provide quality services that enable a participant to remain in their home. However, in spite of SAIL's best attempts to provide quality services and vendors to provide those services, problems may arise.

If an applicant/participant is dissatisfied with any of the services provided under the waiver. Case Managers have the responsibility to assist in solving the problems related to that service.

If services are increased or decreased for any reason, that reason must be thoroughly documented in the case notes. And the Complaint and Grievance guide must be provided to the client. The case manager must fully explain to the applicant/participant why a service has been change and what their appeal rights are.

If the participant and the case manager are unable to resolve the disagreement with the services then the client has the right to appeal the decision to the Director of SAIL. If there an adverse ruling or denial of services the participant has thirty (30) days from the date of the notice, in order to request an Informal Conference. If the participant wishes to continue services during the appeal, they must make the request within ten (10) days from the date of the notice. The participant must send a written request that includes the reason for the dissatisfaction to the SAIL Director.

At the Informal Conference, the applicant/participant will be able to provide any additional information in order to support their position. The participant has the right to be represented by a friend, relative, attorney, or other spokesperson of their choice.

Once the informal conference is completed, the Alabama Medicaid Agency will notify the participant of the decision. SAIL is also notified in writing of the decision.

If the applicant/participant is still dissatisfied with the decision then they have the right to request a Fair Hearing. The Alabama Medicaid Agency will notify then of the next steps to take in the Fair Hearing process.

Once the Fair Hearing is completed, the Alabama Medicaid Agency will notify the applicant/participant of the decision. SAIL is also notified in writing of the decision.

## **5. CONFIDENTIALITY RELEASE**

The Confidentiality Release must be completed at initial intake, redetermination and readmission.

All applicants, participants, or participant's representatives are to be informed of the confidentiality of records. Information will only be used and released for purposes directly related to the administration of the waiver and for the coordination of services. Each year during redetermination a participant needs to sign a release. SEE CONFIDENTIALITY and HIPPA

## **6. DHR NOTICE**

The DHR Notice must be completed at initial intake, redetermination, and readmission.

State and Federal law requires mandatory reporting of suspected abuse, neglect or exploitation, sexual abuse, or emotional abuse.

The Alabama Adult Protective Services (APS) Act of 1976 (Code of Alabama § 38-9-2 through 38-9-11) addresses abuse, neglect, and exploitation of adults who are incapable of protecting themselves and have no one willing or able to protect them. The Law states:

If you are a practitioner of the healing arts or caregiver, you are required by law to report any form of suspected abuse, neglect or exploitation of an adult who is physically or mentally incapable of adequately caring for his or herself. Long Term Care Ombudsmen are also mandated reporters.

All Medicaid approved providers including those who provide home and community-based services are mandatory reporters. This includes all physicians, osteopaths, chiropractors, personal care workers, supervising nurses, case managers, specialists, counselors and caregivers. All of these professions are required to report suspected instances of abuse or neglect.

SAIL staff are required to report suspected any form of abuse, neglect or exploitation. This report will be made to the State of Alabama Department of Human Resources (DHR). SAIL staff must report immediately after finding reasonable cause to believe that an adult in need of protection has been subjected to any form of abuse, neglect or exploitation. Reports may be made orally by telephone or in person. It should be followed by a written report. The phone number to the Adult Abuse hotline at 1-800-458-7214.

Reports can also be made to the sheriff, chief of police or to any County Department of Human Resources. A county office is located in each county within the State of Alabama.

When providing the report it should contain as much basic information as possible, such as the name, address and age of the alleged victim should be included. The nature and extent of injuries, and any facts and circumstances which may assist with meeting the needs of the alleged victim should also be included.

Once SAIL staff has made the report, the county DHR or the appropriate law enforcement authority will make an investigation within seven (7) calendar days after receiving the report. Investigations are initiated immediately when there is immediate danger to health and safety. SAIL staff will work with DHR until a resolution to the report is obtained.

As a mandatory reporter, the Adult Protective Services Act grants immunity from civil or criminal liability to any individual who reports and participates in judicial proceedings concerning reports. An oral report, either by telephone or in person will be made immediately to the Department of Human Resources, Adult Protective Services if there is reasonable cause to believe that a participant is subjected to abuse, neglect or exploitation.

SAIL staff DO NOT need State Office approval to report suspected abuse, neglect or exploitation. Staff ARE REQUIRED to report. Case managers must be document fully and accurately in a case note the incident and subsequent actions. Staff are also required to complete the Critical Incident report and submit to the State Office.

## **7. EMAIL, TEXT and FAX FORM**

The Email, Text and Fax Form must be completed at initial intake, redetermination, and readmission.

In order for an applicant, participant or caregiver to be able to communicate using these alternate forms of communication, they must sign a release. The forms of communication are not as secure as picking up a phone and calling case managers.

It is not a requirement that they agree or give permission for services to be rendered however, case management cannot email, text or fax with them unless specific written permission is provided.

## **8. NOTICE OF PRIVACY PRACTICES**

The Notice of Privacy Practices must be completed at initial intake, redetermination, and readmission. This notice provides information to the applicant or participant on how their health information is used and disclosed.

SAIL understands that medical information is very personal. SAIL is committed to protecting the applicant's/participant's. We understand that medical information is personal and private. SAIL staff will not release information regarding any client to individuals who do not have a need to know. Inherently in the program when ordering services there is information given, however, to every extent possible medical information will not be shared. SAIL staff will only use personal health information when doing their jobs.

This can include, but not limited to: determining eligibility, selecting treatment and plan goals and submitting for payment reimbursement.

Case managers will not be share information without the applicant's, participant's or caregiver's authorization. Applicants, participants and/or caregivers have the right to request a restriction of their health information. This request must be made in writing. SAIL is not required by law to agree to the request. This request will be evaluated on a case-by-case bases. A determination will be made on the merit and written notice will be provided to the applicant, participant or caregiver within 30 days of the written request.

Applicants, participants and caregivers have the right to request confidential communication. This request must be made in writing. The Email, text, fax is one form of confidential communication. Another example would be a different phone number other than their primary number.

Applicants and participants have the right to review their SAIL file. This request must be in writing. The case manager will notify the State Office of this request. State office staff will coordinate this request.

## **9. VOTER REGISTRATION**

The Voter Registration must be completed at initial intake and readmission.

The National Voter Registration Act is commonly referred to as the "Motor Voter" because one part of the law allows an individual to apply to register to vote when they apply for a State of Alabama driver's license or identification card.

Under the National Voter Registration Act, the State of Alabama has also made voter registration available at selected state and local government offices. Applicants/participants may apply to register to vote when they apply for services or recertify for services through SAIL. SAIL staff are to offer this opportunity at the initial intake and any subsequent waiver redetermination.

There are two forms of voter registration:

Traditional – The case manager will assist the client in completing the traditional form. SAIL staff will turn the form over to the ADRS individual in their office responsible for collecting and submitting the voter registration.

Postcard Voter Registration – The case manager will provide the postcard for the applicant or participant to complete and mail to the County Board of Registrars.

Applicant/participant are not required to register to vote in order to be eligible for services. SAIL is only required to offer the service to register.

## **10. PARTICIPANT CHOICE DOCUMENTATION**

The Participant Choice Documentation must be completed at initial intake, redetermination, and readmission.

In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the State has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.

As a participant of the SAIL Waiver Program, the applicant, participant or caregiver have the right to choose an approved service provider/vendor to provide those services that they need. Only those service provider/vendor are designated on the approved vendor choice list.

The Case Manager must explain to the applicant/participant or caregiver the intent of the Participant Choice. The Case Manager must leave a copy of the form in the home.

Vendors or service providers can only provide services in the service area for which they are licensed and approved.

If the applicant/participant prefers a service provider/vendor that is not on this list. The provider must make application to ADRS/SAIL and the Alabama Medicaid Agency, to provide the requested services. If an applicant/participant chooses to wait on the approval of the vendor, the case manager must explain that the process of enrollment can be long. This process of placing a vendor on the approved list will cause a delay in services until the service provider/vendor is approved.

Applicants/participants and caregiver can select a different approved vendor at any time for any reasons. The applicant/participant should provide in writing that they would like to change vendor. They can write a short note such as "I want to change XXXXX provider to YYYYYY provider. The case manager should fully document in a case note, if applicable why a change was requested and from what vendor, to what vendor.

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

With the provider choice form the applicant/participant provides consent to SAIL to share information with vendors providing services.

## **11. VENDOR CHOICE FORM**

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

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

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

It is the responsibility of each District Office to keep a continuously updated list of providers for each waiver service available in that area. It is their responsibility to notify the Waiver Program Specialist of changes in the local vendors. SAIL State Office will provide each local office of the current Direct Service Providers for their service area. A copy of this list is given to each participant, responsible party, and/or knowledgeable other at each redetermination visit, so the participant will always be informed of providers serving his/her area.

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

Special needs of the participant, such as weekend service or specific hours of the day or evening should reflect on the Waiver contract and be documented in the narrative. These needs will be presented to the chosen provider, giving that provider the opportunity to accept or reject the referral. Because the condition of the participant is the primary consideration and the timely initiation of services is paramount, the case manager will have the option of referring to the next provider (as prioritized by the participant, responsible, and/or knowledgeable other) if an affirmation response has not been received from the chosen provider within two (2) working days. The same will hold true if the chosen provider does not respond to a “*call back*” message. When this occurs, dates and persons contacted and other pertinent information must be documented in the narrative.

If the applicant/participant prefers a service provider/vendor that is not on this list. The provider must make application to ADRS/SAIL and the Alabama Medicaid Agency, to provide the requested services. Services cannot be initiated to that provider until they have been approved.

The Vendor Choice Form must be completed at initial intake, redetermination, and readmission.

## **12. PERSON CENTERED PLANNING**

Person centered planning focuses on the people and their needs by putting them in charge of defining the direction for their lives, not on the systems that may or may not be available to serve them. This ultimately leads to greater inclusion as valued members of both community and society. Person centered planning places emphasis on transforming the options available to the person, rather than on 'fixing' or changing the person. Person-centered planning is designed specifically to 'empower' our participants, to directly support their social inclusion, and to directly challenge their devaluation.

Case manager will facilitate person centered planning upon application and every year thereafter at redetermination time. The applicant/participant will determine who they would like to be involved in their person centered plan. A meeting will be scheduled with the participant, case manager, waiver providers and whom ever else the participant chooses to include. The policy is as follows:

- 1) Case Manager will contact the client to allow for sufficient time to get the other person he/she desires at the meeting. A minimum of a month is recommended.
- 2) The case manager will make a copy of the HCBS-1 Plan of Care and carry to the meeting to review all services
- 3) Use one of the person centered planning tool as the guide to determine services and needs. After completion have all parties present at the meeting to sign
- 4) The case manager will document on the Face to face visit form that the POC was reviewed in the person centered planning meeting and that all were in agreement to the services on the new POC.
- 5) Document all activity in the Case Management review browse in SMILE.

## **13. 204 FINANCIAL APPLICATION**

The FORM 204 Financial Application must be completed at initial intake and depending on the situation at readmission.

If a participant is not presently eligible for SSI or Medicaid and is seeking enrollment in the Waiver Program, the MED form 204 financial application form completed. The Case Manager is responsible for providing the form to the applicant/participant and then obtaining the completed form from them. The applicant, participant or caregiver is

responsible for completing the Form 204. The case manager will make a copy of the completed form and place into the case file. The case manager should never complete the financial application for the applicant/participant.

The case manager is responsible for informing the applicant and/or responsible party of the application process. If applicant/participant should be informed that the Medicaid District Office will be requesting additional information, they must provide the information in order to determine financial eligibility. If they do not provide the information, then their application can be denied.

The Medicaid District Office will recertify financial eligibility for each participant on a yearly basis. The case manager should inform the participant the importance of completing this reevaluation. If the District Office does not receive the required information, the participant will lose eligibility and the case will terminate. If the case terminates, services will terminate.

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

#### **14. SLOT CONFIRMATION**

The Slot Confirmation must be completed at initial intake and depending on the situation at readmission.

The slot confirmation form insures to the Medicaid District Office that the medical determination has been made and that there is an available slot for the waiver applicant. This form is only completed in the following circumstances

1. During an initial application.
2. When a client has lost eligibility and has to be resubmitted to the District Office for financial determination.

The slot confirmation demographic information section must be completed by the case manager. It is submitted to the Nurse at the same time the HCBS is submitted. The Nurse will approve the slot confirmation if the medical application is approved and return it to the case manager.

***All forms are located in the Appendix***



**Previous Last Name:**

**Previous First Name:**

The case manager needs to ask if the applicant/participant has used any other names for legal purposes. Such as maiden names, married names, or if the person has had a name change. Those names should be documented, if there is any chance that public benefits have been or are being obtained using that name.

**Address**

**City:\* State:\* Zip:\* County:\***

The address is the living address where the home visits will be made and the services rendered. The case manager must assure that the address is current and complete. If there is a PO BOX or a different mailing address, it is to be listed but the primary address the address where services will take place. Any time an applicant/participant moves or changes their phone number, the case manager must update the Participant information in SMILE immediately upon notification from the applicant/participant.

**Primary Phone:** The number that is used most of the time to contact the applicant/participant.

**Second Phone:** The alternative number used to contact the applicant/participant is the case manager is unable to contact them at the primary number.

**E-Mail Address:** Case managers can only use this form of communication if the participant signed the Email, fax, text form.

**Directions to Home:** Directions to the home are required. The directions must be from the case manager's office to the front door of the participant. These directions need to be specific and accurate.

**Characteristics Primary Race/Ethnicity:** The race or ethnicity that the applicant or participant identify themselves as belonging to. The case manager will need to ask.

Is the client an ADRS staff member? If the answer is no then the case manager can continue with the application.

If the answer is yes, the case manager must notify the State Office Staff immediately by email, providing full demographic information and a short case summary of the needs of the applicant or participant.

*State Office must approve this case at referral and prior to application completion.*

Is the client related to an ADRS staff member? If the answer is no then the case manager can continue with the application.

If the answer is yes, the case manager must notify the State Office Staff immediately by email, providing full demographic information and a short case summary of the needs of the applicant or participant.

*State Office must approve this case at referral and prior to application completion.*

With staff members or their family members the SAIL Coordinator must ensure that the coworkers of the employee are not involved in the direct services of the employee or their family.

**English Speaking Ability:** This documents the functional capabilities to speak English.

**English Reading Ability:** This documents the functional capabilities to read English.

**Primary Language:** If not English, there should be a note in application narrative about the language and whether an interpreter is required.

**Special Needs:** Address any special needs of the participant.

**Transition/Training Current Grade Level:** If the participant is in school, complete the required information.

**Contacts:** The emergency contacts is who the case manager will call when they are unable to locate the participant. There should be at least two identified contacts and the relationship to the applicant or participant.

## **B. INITIAL APPLICATION**

Once the personal information is completed and closed, the case manager can move to the initial application. The initial application consists of:

**Medicaid Application Status:** This will be blank at first, it is populated by SMILE once information is submitted and/or approved.

**Date Submitted:** This field is populated once the application is sent to the Nurse for Determination.

**Referral Date:** The referral date is the date you received the referral for this applicant or participant.

**Initial Contact Date:** This is the date that the case manager had the FIRST initial contact with the applicant or participant.

**Application Date:** The application date is the date the initial application home visit was made and HCBS was signed by the participant. The application date is NOT the date the case manager enters the information in the computer.

**Waiver Eligibility Expires:** This field is populated by SMILE

**Application Type:** This field is also populated by SMILE and will say Initial Assessment, Reinstatement, Readmission or Redetermination

**Prior Control Number:** Prior to submitting a new application for a waiver approval, a prior control number will be generated in the SMILE system. The first three numbers identify the provider of waiver services "8" = SAIL Waiver, and the waiver participant's country code, for example "43" = Lee County. The next six numbers are a sequential run of numbers for approved SAIL Waiver participants, 500-001, 500-002, etc.

This specific prior control number will continue to be used to identify each participant throughout the receipt of services, even if there is a break in service. The prior control number remains assigned to the designated participant and cannot be reused if that participant enters a nursing home or is terminated from the waiver for any reason including death.

Waiver slots retired during a year may be reissued/reused for new applicants after the beginning of the new waiver year. Vacant slots not previously assigned during a waiver year can be used. The prior control numbers and the waiver slots correlate to each other.

**Basic Date Completed:** This is the date that the application was completed.

**Referral Source:** How was this person referred to the waiver program? Were they self-referred, referred by family, referred by another provider? The case manager must identify who referred the applicant/participant for services.

**Other Referral Source:** If the referral source was other, case manager should identify the referral source.

**Marital Status:** Case manager should identify the status of the applicant as never married, divorced, widowed.

**Transitioned from Nursing Home:** If an applicant/participant was a resident of a nursing home and transitioned on to the waiver then the answer is they transitioned. However, if they were released from the nursing home and then applied for services, they did not transition.

**Date Nursing Home Transition Set:** If the person is being released from the nursing home, what date (month, day and year).

**Client lives alone:** Case manager needs to identify if the client lives alone. In the application narrative the case manager MUST identify a care giver. In order to be a waiver participant there must be a care giver identified even if they live alone. There must be someone responsible if there is an emergency, or if the personal care worker is unable to provide services.

**Client Previously Lived:** The case manager is to assess whether they live alone with or without care,

**Emergency Contact: Address: City: State: Zip Code: Phone:**

**Financial/Insurance:** The case manager needs to identify the financial support system of the applicant/participant.

**Number in Family:** How many people are in the family?

If the person is married with children then the entire family must be counted.

If the person is not married yet lives with family, then the only the applicant/participant is counted.

If the person is living with a significant other then only the applicant/participant is counted.

**Number of Dependents:** This number is the spouse and dependent children.

**Family Monthly Income Amount:** The entire family income must be counted.

If the person is married with children then the entire family and family income must be counted.

If the person is not married yet lives with family, then the only income that has to be counted is the applicant/participants income.

If the person is living with a significant other then only the applicants/participants income must be counted.

**Client has Private Medical Insurance:**

**Public Support:** Case manager will report whether the applicant has applied for SSI and SSDI status and if benefits have been determined and approved/allowed or denied. Applicants/participants should have applied for Social Security benefits and a determination made.

The amount of the assistance must be identified. The program type should be identified as well. They include: SSI Aged, SSI Blind, SSI Disabled, SSDI, VA, TANF, General Assistance, Other disability payments and Other/general.

If the applicant receives SSI then the case manager must document the Medicaid number.

If the applicant received SSDI and receives Medicare, then the case manager must identify the Medicare number.

If the applicant has private insurance, then the case manager must document the insurance information, including the name and address of the company; the phone number, the insurance case manager if applicable and the insurance contract number and group number.

The case manager should obtain a copy of the Medicare, Medicaid, and private insurance card for the participant file.

**Impaired Drivers Trust Fund:** The case manager must identify if the applicant has a traumatic brain injury or spinal cord injury resulting in quadriplegia as a result of trauma on or after October 1, 1995.

After the first year the initial application is redetermination.

### **C. HOME ASSESSMENT**

In this section of SMILE, the case manager is documenting the home environment. All sections must be completed and a list of family members and their relation must be provided.

Is the neighborhood secure? If no, in the application narrative, the case manager must document information about the neighborhood and describe the security plan that is in place.

Is the home space adequate? If no, in the application narrative the case manager must describe why the space is not adequate and what plan if any to organize the area to allow more space.

Is the home dwelling sound? If no, in the application narrative, the case manager will describe the home surroundings and provide options if any for improvement.

Is there heating and air conditioning in the home? If no, in the application narrative, the case manager will document how the applicant/participant stay warm in the winter and cool in the summer

Is there a cooking facilities in the home? If no, in the application narrative, the case manager must document how food is stored and prepared and any possible resolutions.

Does the home have a washer and dryer? If no, in the application narrative the case manager will describe how the applicant/participant washes and dries his/her clothing and any possible solution.

Is there a working bathroom with an accessible toilet/tub/shower? If no, in the application narrative the case manager will describe how and where the applicant/participant uses the toilet, takes a bath, and performs other personal hygiene and possible solutions.

Is there an accessible telephone in the home? If no, in the application narrative the case manager will document how the applicant/participant makes and receives calls and will address how contact will be made in the future with the applicant/participant.

Is the home accessible to the applicant/participant? If no, in the application narrative the case manager will describe the home accessibility issues and if any changes can be made to improve the accessibility for the participant.

Is the home accessible to the applicant/participant? If no, in the application narrative the case manager will describe the home accessibility issues and if any changes can be made to improve the accessibility for the service providers.

Are there any physical barriers? If YES, in the application narrative the case manager will address the physical barriers in the application narrative. These barriers may include the home not having a ramp or the doors being too narrow for a wheelchair. The case manager will document a plan to resolve the barrier issue.

Does the family have pets? If yes, in the application narrative the case manager will describe what kinds of pets and where they are kept. The case manager should describe how these pets affect the hygiene and well-being of the applicant/participant.

**Living Situation:** The case manager will document with whom the applicant/participant lives.

**Primary Caregiver:** The case manager will document who is the primary caregiver. In order to be a SAIL waiver participant, there MUST be a primary caregiver in a location in close physical proximity to the applicant/participant. The case manager will identify this person and gather all of their personal information.

**Other Household Members:** The case manager will identify all of the other household members and their relationship to the applicant/participant. Once this page is completed the case manager will close and move to Activities of Daily Living.

#### **D. ACTIVITIES OF DAILY LIVING**

The case manager will address the following specific activities of daily living. They will document whether the applicant/participant needs assistance, needs some help, is unable, or needs no assistance. If the participant is unable or requires any assistance, who currently provides that service and a contact phone number for that person/s. To qualify for services the participant must demonstrate a need for assistance or help in activities of daily living.

Can the Applicant/Participant  
Do housework?  
Go shopping for clothes or groceries?  
Feed self?  
Prepare own meals?  
Do laundry?  
Bathe or shower?  
Dress and undress?  
Comb hair?  
Handle money?

Take medications correctly?  
Walk inside?  
Transfer from bed to chair?  
Walk outside?  
Use stairs?  
Use the telephone?

These areas of daily living skills need to be addressed in the application narrative with a description of the level of care needed and who will be responsible for that care. Only family can be listed on the ADLs where money (\$\$\$\$\$) or medications are involved.

**Medical Devices:** The case manager will address if the applicant/participant is in need of the following medical devices and whether they currently have the device and are using it.

Artificial Limb: Walker: Cane: Lift: Wheelchair: Oxygen:  
The narrative should address if they have it and use it. The case manager should also document if an item is needed what is the plan for obtaining it.

**Elimination Problems:** The case manager will address elimination problems and frequency of the bowel and bladder. If the bowel or bladder are occasional or frequent involuntary, the case manager should address the sanitary evacuation of bowel and bladder in the application narrative.

**Non-Prescription Drugs:** The case manager must document the non-prescription medications that an applicant/participant takes. Examples would be vitamins, over-the-counter medications that are taken on a routine or daily basis.

**Mental Status:** The case manager must document if the applicant/participant has Confusion, Memory Lapses, or Hostility. If the answer to any of these questions is yes, the case manager must document in the application narrative who is the responsible caregiver and any other material information.

**Sensory Impairments and Accommodations:** The case manager should document if there is any Speech, Hearing or Sight issues. If yes, they must be identified and addressed in the application narrative. Do they need Dentures, Hearing Aids, or Glasses? The case manager would need to address the plan for obtaining the needed items.

**Agencies Providing Services in Home or Community in Past 3 Months.** The case manager must identify the agencies or services that are being provided to the applicant/participant in the home. Any non-waiver service that the applicant/participant is receiving must be listed such as home health, transportation, dialysis, physical therapy, meals, VR services, and IL services or other.

Home health Aide works for a Home health company (HHA)  
Personal care worker is provided by a waiver (PCW)

This must be complete at the initial application and at every redetermination.

**Waiver Income.** The case manager must choose the correct income information from this drop down box. This drop box determines how this application will be processed.

330% SSI is for those individuals that have social security disability and other retirement and they do NOT have Medicaid. This requires a FORM 204 and slot confirmation.

Institutional Deeming is for those individuals that have social security disability and other retirement and have a spouse with resources and they do NOT have Medicaid. This requires a FORM 204 and slot confirmation.

SSI is for those individuals that only receive social security insurance and DO receive Medicaid.

Once the SMILE page is complete the case manager will close it. The case manager will skip the Application Narrative (for now) and move to Admission and Evaluation.

#### **E. ADMISSION AND EVALUATION - HCBS**

SAIL Waiver recipients must meet Alabama's nursing facility level of care. For new applications, redeterminations and readmissions, a minimum of two (2) admission criteria are required.

The case manager performs a thorough assessment of the applicant/participant's living situation, their ability to perform activities of daily living, available community resources, and support from family/others. The applicant/participant and the case manager develop a plan of care to address any gaps which place the applicant/participant at risk for nursing home placement.

The case manager is responsible for the completion of the HCBS (all three pages). And, is responsible for obtaining the most reliable and accurate information available at no cost to SAIL. The HCBS form should not be completed by the applicant/participant.

Once the case manager has completed the HCBS and the applicant/participant has signed it, the form is sent to the person's medical provider for signature. A blank HCBS form should NEVER be sent to medical personnel for them to complete.

The HCBS on yellow paper has been signed by the applicant/participant or responsible caregiver and the qualified medical provider. Now it is time to translate this information from the paper version to the SMILE version.

The applicant must agree with Freedom of choice, choosing waiver and state recovery. If the blocks on the original HCBS are not signed by the applicant/participant the application cannot be processed and a letter of denial is sent to the applicant.

**Applicant/Participant has been given a choice between community services and nursing home and has chosen community services?** FREEDOM of CHOICE. The applicant/participant signs showing they have been given a choice between community and nursing facility care, this is “Freedom of Choice”. By signing this section, the participant is choosing community based SAIL waiver in lieu of nursing home Medicaid and placement.

**Applicant/Participant has authorized release of information for the purpose of determining eligibility?** It also provides authorization for SAIL to share and gather information with the primary medical provider

**Have they signed the statement of State Recovery?** The State Recovery Program was established under federal law. It requires the Alabama Medicaid Agency to recover the costs paid by the Agency from the estates of deceased Medicaid recipients.

**Applicant/Participant signature date:** This date is when the initial application was taken and is the admission date. This date should match the date on the original HCBS.

**Medical Status Information:** If the applicant/participant has been diagnosed with Mental Retardation, Mental Illness, or Developmental Disability, the case manager should mark YES to the correct diagnosis. If no diagnosis, then NO should be marked.

**Check if Applicant/Participant has the following evaluations:** If the applicant/participant has had a Psychological or Psychiatric evaluation then the case manager would mark yes, if not then they would mark no.

**Current Diagnosis:** (check all that apply, at least one must be checked): The qualifying diagnosis are quadriplegia, traumatic brain injury, amyotrophic lateral sclerosis, multiple sclerosis, muscular dystrophy, spinal muscular atrophy, severe cerebral palsy, stroke and other substantial neurological impairments, severely debilitating diseases or rare genetic diseases. Therefore, at least one of the qualifying diagnosis must be marked on the HCBS original and must be checked in SMILE from the following list.

The primary disability and secondary condition(s) must include the ICD-10 code. The code should be written beside the corresponding disability.

Alcoholism    Alzheimer    Amputation    Anemia    Arthritis    Asthma  
Cancer    Cerebral Palsy    Chronic Renal Failure    COPD    CVA  
Dementia    Diabetes    Emphysema    Epilepsy    Glaucoma  
Heart Disease    Hernia    HIV/AIDS    Hypertension    Multiple Sclerosis  
Organic Brain Syndrome    Osteoporosis    Paralysis    Parkinson's Disease  
Respiratory    Skeletal Trauma    Skin Disease    Spinal Cord Injury    Thyroid  
Traumatic Brain Injury    Tuberculosis    Ulcer

**Additional Diagnosis (6 Lines):** On the original HCBS the case manager or qualified medical provider would have put any other qualifying diagnosis or secondary diagnosis. These should be accurately transferred into SMILE. Examples: Neurogenic Bowel and Bladder, Club foot, Seizure Disorder.

**Special Diet:** The case manager would document any special diet and perimeters of that diet. For example: Low sodium or Low calorie. This space is also used to document feeding supplements such as 5 cans of Boost per day and 180cc of water. If no special diet the case manager can leave it blank.

**Allergies:** If the applicant/participant has no allergies then the case manager says no. If they do then mark yes and describe. An example would be latex, penicillin.

**Free from Communicable Diseases:** If the answer is marked No, medical justification and documentation is required from the qualifying medical provider.

**Admission Criteria** Must meet 2 criteria for Initial, Redetermination and Readmission.

The criteria should reflect the individual's capabilities on an ongoing basis and not isolated, exceptional, or infrequent limitations of function in a generally independent individual who is able to function with minimal supervision or assistance.

In order to be eligible an applicant must meet two criterion both for initial application and redetermination.

The admission criteria are as follows:

**A. Administration of a potent and dangerous injectable medication and intravenous medication and solutions on a daily basis or administration of routine oral medications, eye drops, or ointment.**

When **A** is marked. It indicates the administration of a potent and dangerous medication. Medications must be listed in the medication section. Please note that only 12 medications can be listed in SMILE under medications. All additional medications are listed under Section G of the narrative. Case managers should list ALL medications.

**B. Restorative nursing procedures (such as gait training and bowel and bladder training) in the case of clients who are determined to have restorative potential and can benefit from the training on a daily basis per physician's orders.**

When Items B-J are marked, then an explanation must be provided in the comment section and in Application narrative. When a restorative procedure is used such as Physical therapy or Occupational therapy the standard for Medicaid is a minimum of three times per week for that service to qualify as restorative.

**C. Nasopharyngeal aspiration required for the maintenance of a clear airway.**

**D. Maintenance of tracheostomy, gastrostomy, colostomy, ileostomy and other tubes indwelling in body cavities as an adjunct to active treatment for rehabilitation of disease for which the stoma was created.**

When **D** is marked, the type of ostomy should be circled or written in the space open under **D**. An explanation should be written in the comment section and in Application narrative. Who is responsible for the maintenance should also be addressed.

**E. Administration of tube feedings by naso-gastric tube.**

The type of feeding should be listed in the Special Diet. Specific type, dose and route should be listed. In the application narrative, who is responsible for the feeding should be documented.

**F. Care of extensive decubitus ulcers or other widespread skin disorders.**

Documentation of the care of the ulcer or skin disorder should be made in the comment section as well as the application narrative. Who is responsible for the care should be also be documented.

**G. Observation of unstable medical conditions required on a regular and continuing basis that can only be provided by or under the direction of a registered nurse.**

Item G is an episode of an acute illness or exacerbation of a chronic illness that has required active treatment in the preceding 30-60 day period. If “observation of unstable conditions” is used to qualify an applicant for services, documentation of exactly what the condition(s) are and what is necessary (active treatment of the condition) to control them is required.

Active treatment is defined as: i.e., doctor's orders, home health nurse orders, change in medication or new medication as part of the active treatment of the condition 30 to 60 days prior to the date of submitting the application for admission. This documentation is placed in the comment box or placed on the Plan of Care under the Non Waiver objectives, with all boxes completed with frequency and dates.

Example for comment box: Applicant gives a history of visiting MD on a monthly basis. She reports that during her March visit that the physician increased her Blood pressure medicine to two times a day, or changed her potassium to once a day, or gave her a new prescription for arthritis that she takes twice a day.

Example for Plan of Care page, Provider=physician, frequency=1xper month, during March visit physician increased B/P med to 2xday, decreased insulin to 20 units.

All cases where the doctor marks Criteria G must have six (6) months of the individual's medical notes documenting the unstable medical condition. It must be forwarded from the doctor. In cases where the individual's doctor has ordered the Home Health Nurse to provide a skill, the case manager must obtain the visit notes for the previous six (6) months.

IF CASE IS DENIED, then go back and gather more support documentation and resubmit. Case Manager will have to encourage the participant to visit with their physician for more documentation upon redetermination and especially for new applicants who may not satisfy the definition of unstable medical condition when applying for services because the Medicaid guidelines related to definition of chronic stable state: "not during a period of any acute illness or an exacerbation of their underlying disease" A person is said to have a chronic condition or a stable condition when it has lasted for more than 6 months and there have been no significant changes or active treatment in the preceding 30-60 day period.

**H. Use of oxygen on a regular or continuing basis.**

The liters/day should be listed on page 3 of the HCBS as well as the application narrative.

**I. Application of dressing involving prescription medications and aseptic techniques and/or changing of dressing in non-infected, postoperative, or chronic conditions per physician's orders.**

The prescription medications should be listed on page 3 of the HCBS. The techniques should be documented in the comment section of the SMILE HCBS as well as in the application narrative.

**J. Comatose client receiving routine medical treatment.**

If an individual meets one or more ADL deficits within criterion (k), they must also meet an additional criterion, (a) through (j), accompanied by supporting documentation, as is currently required. Multiple items met under (k) will still count as one criterion.

**K. Assistance with at least one of the activities of daily living below on an ongoing basis:**

Criterion K should reflect the individual's capabilities on an ongoing basis and not isolated, exceptional, or infrequent limitations of function in a generally independent individual who is able to function with minimal supervision or assistance. Multiple items being met under (K) will still count as one criterion.

1. Transfer - The individual is incapable of transfer to and from bed, chair, or toilet unless physical assistance is provided by others on an ongoing basis (daily or multiple times per week).
2. Mobility - The individual requires physical assistance from another person for mobility on an ongoing basis (daily or multiple times per week). Mobility is defined as the ability to walk, using mobility aids such as a walker, crutch, or cane if required, or the ability to use a wheelchair if walking is not feasible. The need for a wheelchair, walker, crutch, cane, or other mobility aid shall not by itself be considered to meet this requirement.
3. Eating - The individual requires gastrostomy tube feedings or physical assistance from another person to place food/drink into the mouth. Food preparation, tray set-up, and assistance in cutting up foods shall not be considered to meet this requirement.
4. Toileting - The individual requires physical assistance from another person to use the toilet or to perform incontinence care, ostomy care, or indwelling catheter care on an ongoing basis (daily or multiple times per week).
5. Expressive and Receptive Communication - The individual is incapable of reliably communicating basic needs and wants (e.g., need for assistance with toileting; presence of pain) using verbal or written language; or the individual is incapable of understanding and following very simple instructions and commands (e.g., how to perform or complete basic activities of daily living such as dressing or bathing) without continual staff intervention.

6. Orientation - The individual is disoriented to person (e.g., fails to remember own name, or recognize immediate family members) or is disoriented to place (e.g., does not know residence is a Nursing Facility).
7. Medication Administration - The individual is not mentally or physically capable of self-administering prescribed medications despite the availability of limited assistance from another person. Limited assistance includes, but is not limited to, reminding when to take medications, encouragement to take, reading medication labels, opening bottles, handing to individual, and reassurance of the correct dose.
8. Behavior - The individual requires persistent staff intervention due to an established and persistent pattern of dementia-related behavioral problems (e.g., aggressive physical behavior, disrobing, or repetitive elopement attempts).
9. Skilled Nursing or Rehabilitative Services - The individual requires daily skilled nursing or rehabilitative services at a greater frequency, duration, or intensity than, for practical purposes, would be provided through a daily home health visit.

Also note, Criterion (a) is also the same as Criterion (k) 7. Therefore, if an individual meets criterion (a), criterion (k) 7, cannot be used as the second qualifying criterion.

Additionally, Criterion (g) is the same as Criterion (k) 9. Therefore, if an individual meets criterion (g), Criterion (k) 9, cannot be used as the second qualifying criterion.

**Comments:** The case manager must document and justify any criteria marked. For example “A”. Prescribed medications are taken on a daily or routine basis. If the participant is receiving wound care, the case manager must document where the wound is locate, a description of the wound, the treatment performed, how often it is done, who does the treatment and who trained them to do the treatment.

### **Medications Prescribed:**

All medications are to be listed in SMILE and must exactly match those on the original HCBS. Each must include Strength, Dosage, Route, and Time. Any medications in excess of 12 are to be listed on the Application Narrative under section G.

Examples of medications and how to list them follow:

Phenergan 25mg po bid, Baclofen liquid 10mg po tid, Morphine sulfate 100mg, 1 po bid

Medical term and abbreviations are often used on the HCBS, The case manager should ensure that only the common abbreviations or approved abbreviations are used.

Common abbreviations:

PO	Oral or by mouth	IM	Injection into the muscle
SQ	Subcutaneous injection	INH	Inhaler
REC	Rectal	PRN	As needed
Q	Every	QD	Everyday
QOD	Every other day	QHS	Daily at bedtime
QID	Four (4) times per day	TID	Three (3) times per day
BID	Two (2) times per day		

**Certifying Physician:** The qualified medical provider must sign after the applicant/participant has signed and date the form. The medical provider is never to sign the HCBS prior to the client. If the qualified medical provider's signature is not legible then the case manager will obtain the full legal name of the medical provider and the case manager will print it in the area above or below the provider's signature.

Medical certification is obtained from a qualified medical provider. Information gathered by the case manager and the qualified medical provider is forwarded to the Nurse Reviewer for a Level of Care determination.

ANY changes made to the original HCBS must be initialed by the case manager with the date and addressed in the Application Narrative, section G.

*The qualified medical provider cannot sign prior to the applicant/participant. The qualified medical provider MUST sign after the applicant/participant.*

## **F. DISABILITY BROWSE**

The case manager must have the HCBS with a qualifying disability as well as have in their possession medical records that document Qualifying disability. The qualifying disability MUST be listed. In SMILE the qualifying disability is the disability code that is listed in order 1.

The case manager must populate the disability browse in the following order:

order 1 SAIL qualifying disability

Example: TBI, QUAD, MS, MD, CP, Stroke, Other neurological disabilities, etc.

order 2 Secondary qualifying diagnosis

Example: items listed above, seizures, neurogenic bowel and bladder, wounds, etc.

order 3 Other diagnosis codes

Examples: High blood pressure, diabetes, asthma.

Order 4 Other diagnosis codes

The order to which the diagnosis is categorized, is how Medicaid is billed for reimbursement of services. Only qualifying disability for the waiver can be billed.

Example: If the case manager lists asthma in order 1. (Qualifying disability). Reimbursement is rejected because asthma is not a qualifying disability. It is the case manager responsibility to ensure that documentation of qualifying disability is accurate, that the code is accurately identified and proof of disability is in the file.

## **G. CARE PLAN**

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

The Plan of Care is developed jointly with the participant utilizing a person centered planning process. During this process, the case manager will address the specific needs of the participant to include health and safety, access to the community and opportunities to engage in employment and services within the community and the ability to control resources.

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

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

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

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

All services must be listed on the Plan of Care as written in the Medicaid Waiver document.

Waiver services should be listed in the first section of the Plan of Care where indicated.

All non-waiver services should appear on the Plan of Care where indicated.

Services will be delivered according to the Plan of Care.

Payment will not be made for services not listed on the Plan of Care

Services must be identified on the Plan of Care by correct service name in the approved waiver document.

Services listed on the plan must be based on the applicant's diagnosis as stated on the HCBS.

All services, both waiver and non-waiver, which are needed to maintain the individual within the home and community should be listed on the plan. All services provided, including those from other resources, including informal family support, must be included.

Exact Waiver service category titles must be used on the plan.

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

Non-waiver services which may include, home health, routine visits to the physician, transportation, dialysis, physical therapy, meals, ADRS services, SAIL-IL, and any other entities providing services. Case manager must ensure that every non-waiver service and every agencies providing services in home or community listed on the ADL page must be listed on the plan of care.

The plan of care will be reviewed a minimum monthly and will indicate/document any adjustments in services as needed.

Examples:

Non-Waiver	Family
To support community living by social, financial, medical assistance including assistance with ADLs, meals, transportation and emergency/safety concerns.	
Waiver	SAIL
CASE MANAGEMENT	Participant will receive assistance to waiver and other needed medical, social, or educational services
Waiver	GOOD FOR YOU RESPONSE
PERS-SET UP	One time service to install. To provide a lifeline to assure safety.
Waiver	GOOD FOR YOU RESPONSE
PERS-Monthly	To provide safety response in case of an emergency.
Waiver	YOU'LL GET A BATH HOMECARE
PERSONAL CARE	To provide a bath, dressing, light housekeeping and meals. (This should also be detailed in number of hours per week/per day)

The care plan must have the following information:

On the initial applications, service date should remain blank. When the Eligibility notification is sent and the page printed for the file, the case manager must enter the beginning date of each service.

After the initial plan, all plan must have the date the service begins and if a service ends, the date it ends.

When changes in the plan of care are required the case manager will do the following:

If the change is in Personal Care, a new provider contract is written and mailed/emailed to the provider for signature and reflected in the case note or narrative and a copy placed in case file.

The case narrative should also reflect the need for the revision and the authorization by the case manager. Anytime services are removed or reduced a ten (10) day notice should also be sent to the participant. It should be documented in the case narrative and a copy in the participant's file.

When there is a change in provider or frequency, put an ending date on that service and the new service must be re-entered on the Plan of Care with the new service date. The narrative should reflect the reason for change.

The start dates for Assistive Technology, Environmental Accessibility Adaptations and Personal Emergency Response System is the date the PA Process begins (which is the date of the price quote received from the Vendor).

Ending dates for Case Management, Medical Supplies, Personal Care, PERS (monthly), is the last date that the participant received services. Ending dates for Assistive Technology and Environmental Accessibility Adaptations is the date the participant signs the Participant Satisfaction form indicating satisfaction.

When an application has been approved and services have begun, it is the case manager's responsibility to reassess the needs and progress of the participant periodically.

The Plan of Care must be reviewed and initialed every (60) days by the case manager.

## **H. APPLICATION NARRATIVE**

The application narrative is completed by the case manager. The narrative is divided into section and must fully address the following:

### **Describe personal background, disability, and home environment (20 lines):**

Document who is the primary caregiver.

Address Health and Welfare of the client.

Document the medical condition and disability.

Describe personal background and home environment.

Describe the service setting to determine that participant is not residing in a setting that is presumed to be institutional.

Document what assistance is needed and the degree to which it is required.

Describe whether the client is at risk and the plan in a risk situation.

Describe Participant Choice.

Describe any barriers or obstacles

**Describe needed Waiver services, justification of services, expected benefit of services, and provider of services, if selected. (20 lines):**

Describe what service is being provided and how often is it provided.

Describe how the service is benefiting the applicant/participant, and who is providing the service.

**Participant has signed choice of provider form.**

If no, explain in the narrative why the provider choice form has not been signed.

**Describe non-waiver services, justification of services, expected benefit of services, and the provider if selected. (20 lines):**

Describe what services are being provided and how often and who provides them and how they are being obtained if applicable. All non-waiver services listed on the ADL page and plan of care such as home health, routine visits to the physician, transportation, dialysis, physical therapy, meals, ADRS services, SAIL-IL, and any other entities providing services, must be listed here as well.

Describe what benefit the applicant/participant receives from the service(s).

**Describe any similar benefits (10 lines):**

Medicare, Private insurance, or another medical coverage.

**Document discussion of Rights and Responsibilities (10 lines):**

The case manager will discuss providing the applicant/participant or responsible caregiver with the policies and procedures regarding services under the waiver. The case manager must notify the client that monthly home visits are required and must document that they have done so. They will discuss the forms that the applicant/participant were provided at initial intake and at redetermination such as Medical Supply Participant Understanding, Waiver Responsibilities, Complaint and Grievance Guide, Confidentiality Release, DHR notice, Notice of Privacy Practices, Participant Choice Documentation and Vendor Choice Form.

**Document Emergency Protocol has been addressed (10 lines):**

The case manager will document what emergency plan the applicant/participant has, including who is responsible. Describe what actions will be taken in that emergency,

**Section G-Other Information**

Any additional medications that could not be listed on the Admission and Evaluation in SMILE will be listed in this section. As well as any information pertaining to changes to the HCBS made by the case manager after consultation with the physician's office.

## **I. SPECIAL PROGRAMS**

The Case Manager must gather information regarding all the programs that the applicant/participant has participated in and currently enrolled. These programs and their services should be described in the application narrative. This SMILE page details out some of the more common programs. The case manager should select all the program to which the participant receives benefits. Two Special Programs that will be marked are SAIL and Social Security Administration. At least one more program should be identified.

## **J. ELIGIBILITY FOR HOMEBOUND DOLLARS**

Individuals cannot be on Homebound and SAIL waiver at the same time. However, there is a mechanism if the participant loses Medicaid permanently that they can be transferred to the Homebound program using this SMILE field. This must have prior written approval from the SAIL Coordinator.

## **K. THE CASE IN COMPLETED IN SMILE**

Once all the forms are signed and the entire case is documented in SMILE, the case manager will electronically submit the case to the Nurse for determination. The case manager will scan and email the original to the Nurse for her to review. She will either correct and send back to the case manager or approve. IF the participant is Institutional Deeming or 300%SSI, the slot confirmation must also be submitted to the Nurse. On the Application page under Medicaid Status it will say Nurse Determination. The case manager must send the Nurse an email stating the case is ready for determination. It is the case managers responsible to ensure that all the information on the application is factual, detailed and in the case file for the Nurse to make the determination.

If the Nurse approved, on the Application page under Medicaid Status it will say Ready to Submit for those individuals that have Medicaid. This case will electronically transmit over to Medicaid and SAIL will receive an approval in 24 to 72 hours.

For those individuals that require the financial determination, once the nurse approves, the application page will under Medicaid status will say Awaiting District Office. The FORM 204 and Slot confirmation must be sent to the District Office. Depending on whether the District Office gets all the required information in a timely manner, this process can take 30 to 120 days.

The case managers are responsible for providing the correct, accurate and complete information on the applications they submit. It is also their responsibility to inform the applicant/participant regarding the time frames for approval.

If the Nurse does not approve, the case will be placed back in draft status for the case manager to correct and an email sent to the case manager to review the case. The case manager has three days to correct the information requested by the Nurse. What needs to be corrected will be listed under the SMILE page Nurse Determination. The Nurse must provide detailed instructions for the corrections. Once the case manager has made the corrections, the case will be submitted to the Nurse for determination.

## **L. NURSE DETERMINATIONS**

What exactly is the Nurse looking for? The Nurse is making the determination if the applicant/participant meets the medical criteria to be enrolled in this waiver. The Nurse will ensure that the applicant/participant meets the nursing home level of care and fall within the target group to be served.

The Nurse will assure that all aspects of the application were completed by the case manager within the policy and procedures. The Nurse will check for thoroughness and correctness in the application. They will also check the ICD-10 Diagnosis codes to assure that the primary disability is listed as primary and the correct code is marked based on the HCBS and medical records.

Initial applications can be submitted to the Nurse at any point for review and determination.

A transfer from Waiver to Waiver must be sent in draft status prior to the 5<sup>th</sup> of the month, for determination for the 1<sup>st</sup> of the next month. The transfer stays in draft status until the 1<sup>st</sup> of the month and is then placed in status for Nurse review.

Complete and accurate redetermination packages must be to the Nurse by the 8<sup>th</sup> (eighth) of the redetermination month. Once the application/redetermination is received by the Nurse, he/she has (5) days to return it to the case manager with her decision.

If the application is complete, then it will be sent on through electronic transfer to Medicaid.

If the application requires correction, the Nurse will make notes for correction in Nurse Determination and place it back in draft status for the case manager to correct. The nurse will also send the case manager an email stating it is back in draft status. If it is returned to the case manager for corrections, the application is due back to the nurse in 5 days with all corrections made.

If the Nurse is unable to make the determination based on the medical information and the case management narrative and documentation the case will be forwarded to Medicaid.

If the Nurse determines that the applicant does not meet criteria, the case will be denied and the applicant will receive appeal rights.

#### **M. NURSE UNABLE TO DETERMINE**

If the Nurse is unable to make the determination on whether the applicant/participant is eligible for the program. The Nurse will email the SAIL Coordination or Waiver Program Specialist with the facts.

If after further discovery it is determined that SAIL is unable to make the determination, the application will be sent to the Alabama Medicaid Agency.

In order to follow this process the case manager must obtain additional medical information, (with diagnosis and pertinent information) such as physician office notes, hospital records, etc., necessary for the Medicaid Physician to make a medical disability determination.

The Waiver Program Specialist will review and prepare a copy for State Office records. The HCBS-1 Application form, the Application Narrative, and all of the additional information will be sent to Medicaid Long Term Care, Admissions Records Division. The Medicaid nurse reviewer will then attach the forms necessary for the disability review and route this to the Medicaid Physician.

The Medicaid Physician will determine medical appropriateness as well as disability determination on these individuals and approve or deny for the waiver. If the Medicaid Physician approves the case, Medicaid will notify SAIL. After receiving the medical eligibility approval from Medicaid, the MED204 will be signed by the SAIL Nurse and forwarded to the local District Office

# **Chapter 6**

## **Initiation of Services**

### **And**

## **Case Management**

Once the case is eligible and in service status, the case manager must visit the participant within (5) working days to finalize the plan of care and choice of providers.

The Eligibility Page will specify a beginning date of eligibility for Waiver services. Any services rendered prior to this date will not be paid under the waiver. Waiver services are not retroactive.

By the beginning of each month, eligibility status should be verified and documented on each participant prior to the end of the first week of the month by accessing the MSIQ screen.

#### **A. SERVICE INITIATION**

Once the case manager receives the notification of eligibility, services should be implemented and provided according to the Plan of Care. The Plan of Care is developed jointly with the participant utilizing a person centered planning process. During this process, the case manager will address the specific needs of the participant to include health and safety, access to the community and opportunities to engage in employment and services within the community and the ability to control resources.

#### **B. RE-EVALUTATION OF WAIVER SERVICES**

A re-evaluation of a waiver service can occur at any time that it is necessary to assess the need for additional waiver services. A re-evaluation must occur annually at redetermination time. When a re-evaluation occurs the applicant/participant discuss needs and services. The case manager must make an informed decision regarding the continuation and/or revision of waiver services.

#### **C. WAIVER SERVICES**

**Case Management (CM)** assist individuals who receive waiver services in gaining access to needed and desired waiver and other State Plan services, as well as needed medical, social, educational and other appropriate services, regardless of the funding

source for the services. CM services may be used to locate, coordinate, and monitor necessary and appropriate services.

CM activities can also be used to assist in the transition of an individual from institutional settings, such as hospital, and nursing facilities into community settings. The case manager will assist in the coordination of services that help maintain an individual in the community. CM activities may also serve to provide necessary coordination with providers of non-medical and non-waiver services when the services provided by these entities are needed to enable the individual to function at the highest attainable level or to benefit from programs for which the person may be eligible.

Case managers are responsible for ongoing monitoring of the provision of waiver and non-waiver services included in the individual's Plan of Care. CM is a waiver service available to all SAIL Waiver clients. Case Managers assist clients to make decisions regarding long term care services and supports. CM ensures continued access to waiver and non-waiver services that are appropriate, available and desired by the client.

Case Management service provided prior to waiver approval are considered administrative.

Once approved and in service status at least one face-to-face visit is required each month in addition to any other case management activities. Activities after approval are direct services as related to the specific participant.

**Personal Care** provides assistance clients with activities of daily living, specifically getting in and out of bed, bathing, dressing, personal hygiene and grooming. This service may include assistance with meal planning, preparation and eating, but does not include the cost of the meals themselves.

When specified in the plan of care, this service may also include such home support that is essential to the health and welfare of the participant including housekeeping chores as bed making, light cleaning (dusting and vacuuming), and light laundry. These services are incidental to the care furnished, and directly benefit the health and welfare of the individual, not that of the participant's family. They can also perform basic monitoring of the client, such as skin condition while bathing, excessive sweating, abnormal breathing, abnormal lethargy, and recognition of emergencies.

They can perform Medication monitoring, e.g., the type that would consist of informing the client that it is time to take medication as prescribed by his or her physician and as written directions on the box or bottle indicate. It does not mean that the PCW is responsible for giving the medicine; however, it does not preclude the PCW from handing the medicine container to the client. Under no circumstance should any type of skilled medical service be performed by the PCW.

***Personal Care service is not an entitlement. It is based on the needs of the individual client. Personal Care service should not be used for respite care.***

SAIL makes every attempt to secure qualified providers. Family members and friends as personal care workers are strongly discouraged. Family members that are already providing services will be allowed to continue as the personal care worker until such time

that another initial visit by a personal care agency is required. If the services terminate for any reason or if another personal care worker takes the place of the family member, that family member will be disqualified from providing the service in the future.

Family member and friends can only be personal care worker if they have been approved to do so by the SAIL state office. If approved, the family member or friend, must meet the additional criteria: Meet all the educational and experience qualifications for a provider of care; are only providing personal care services; there is adequate justification as to why the relative or friend must be the provider of care; and prove there is a lack of other qualified providers in the geographic area.

The maximum limit of services is 25 hours per week, with a maximum daily limit of 5 hours. Only with permission of the SAIL state office can a participant receive more than 5 hours per day.

**Evaluation of Assistive Technology** provides for an evaluation and determination of the client's need for Assistive Technology. The evaluation must be physician-prescribed and be provided by a therapist licensed to do business in the State of Alabama who is enrolled as a provider with the Alabama Department of Rehabilitation Services (ADRS). The assessment will relate to various physical skills and functional ability including neuro-muscular, coordination and control, balance and ambulation.

The physical therapist's evaluations will allow only medically necessary equipment and devices to be authorized.

The service may also be provided to assist an individual to transition from an institutional level of care to the home and community based waiver.

The assessment must be performed by a graduate from an accredited Physical Therapy institution and possess an Alabama license in Physical Therapy. They must be enrolled as a provider with ADRS and have no financial or other affiliation with a vendor, manufacturer or manufacturer's representative of assistive technology equipment/devices.

Reimbursement for this service will be the standard cost per evaluation as determined by Alabama Medicaid Agency and ADRS.

Services will be authorized using the Authorization.

**Environmental Accessibility Adaptations** are physical adaptations to the home, identified by the participant's plan of care and are necessary to ensure the health, welfare and safety of the individuals, or which enables the individuals to function with greater independence in the home and without which, the recipient would require institutionalization.

These adaptations may include the installation of ramps and grab-bars and/or the widening of doorways in order to accommodate the medical equipment and supplies.

Excluded are those adaptations or improvements to the home which are not of direct medical or remedial benefit to the participant, such as floor covering, roof repair, heating and central air conditioning, etc.

Adaptations which add to the total square footage of the home, any type of construction affecting the structural integrity of the home, changes to the existing electrical components of the home, or permanent adaptations to rental property are also strictly prohibited.

The provider will be capable of constructing or installing the needed apparatus. Any construction/installation completed must be in accordance with state and local building code requirements, American with Disabilities Act Accessibility Guidelines (ADAAG) and done by a licensed contractor.

This service may also be provided to assist an individual to transition from an institutional level of care to the home and community based waiver.

Limits on EAA are \$5,000 per waiver client for the entire waiver lifetime. Any expenditure in excess of \$5,000 must be approved by the State Coordinator and the Medicaid designated personnel.

The service must be processed through the Prior Approval process and must receive approval from the Alabama Medicaid Agency before the service can be provided. The service will be authorized when the prior approval propagates an authorization.

Upon completion and receipt of the service the participant must sign and date a form acknowledging receipt and satisfaction of the service.

Below is the current ramp policy:

#### **RAMP POLICY**

What do you do if your client needs a ramp built or repaired in order to access his/her home? Although there are different procedures for each program, SAIL staff will always refer the client name and demographic information to the RE&AT (Rehab Engineer & Assistive Technology) staff for ramp evaluation. Once you have decided your client needs a ramp, you will take several pictures of the structure where the ramp should be located for the RE&AT to look at. Because the home visit needs to include both you and RE&AT staff, get availability from RE&AT staff and make an appointment with the client that you can both attend. Don't forget to confirm the appointment with RE&AT staff.

#### ***New Ramps:***

Once the initial home visit is made for a NEW ramp, the RE&AT staff will provide a dimensioned conceptual drawing to you. Then SAIL and RE&AT staff will determine together whether an aluminum or a conventional ramp is appropriate for the client. This decision will be based on the site of the ramp and the approximate cost of each option. The client and/or the family must be in agreement regarding the size and placement of the ramp.

If you have a ramp that because of space or other factors, may not be to ADA compliant, it will be upon the discretion of the RE&AT whether this is an appropriate ramp referral.

If you and RE&AT staff determine that the best choice for your client is an **aluminum** ramp, then you can use a DME (durable medical equipment) vendor that has the license to sell, deliver, and install DME, such as aluminum ramps. These vendors are the traditional DME companies, such as Azalea. In this scenario, the DME vendor is responsible for the delivery and set up of the ramp following the RE&AT staff recommendations. Once you make the decision to proceed with an **aluminum** ramp, get a quote from the vendor. You are responsible for taking the drawings to the vendor for the cost estimate. The RE&AT staff is NOT responsible for providing cost estimates or quotes for materials. Any estimate s/he might provide when you are reviewing options, etc., is not a quote and cannot be used for authorization purposes. When you have the vendor quote, complete the "Prior Approval" page in SMILE and submit to the SAIL director and the Waiver program specialist in Montgomery. When they approve this, they will send it to Medicaid for approval. Do not proceed until you receive approval from Medicaid via the State SAIL office. (This step is necessary for Waiver participants only.) DO NOT PROCEED WITHOUT PRIOR APPROVAL.

If you and RE&AT staff determine that the best choice for your client is a **conventional wood** ramp, then you must use a licensed building contractor (or volunteer labor in the case of Independent Living or Homebound clients only). The person must be licensed as a building contractor by the state, have proper credentials, and have the ability to deliver an accurate quote and site build or make accessible modifications. They must be on the STAARS vendor list as well as ADRS vendor list. *[Note that a DME vendor is not licensed as a contractor, and, therefore, you cannot use one to build a conventional ramp for Waiver participants. Additionally, you cannot use a third party through a DME or other contractor to build or repair the ramp. The work must be performed by the person presenting the quote. However, volunteers may be used to build ramps for Independent Living and Homebound clients.]* Once you make the decision to proceed with a **conventional wood** ramp, get a quote from the vendor. You are responsible for taking the drawings to the vendor for the cost estimate. The RE&AT staff is NOT responsible for providing cost estimates or quotes for materials. Any estimate s/he might provide when you are reviewing options, etc., is not a quote and cannot be used for authorization purposes. When you have the vendor quote, complete the "Prior Approval" page in SMILE and submit to the Waiver program specialist in Montgomery. If the quote for the ramp places the individual over the life time cap for environmental adaptations, then you must write a justification for why this participant should be allowed to go over the capitated rate. The SAIL Director must approve when a participant's request goes over the life time cap. When they approve this, they will send it to Medicaid for approval. Do not proceed until you receive approval from Medicaid via the State SAIL office. (This step is necessary for Waiver participants only.) DO NOT PROCEED WITHOUT PRIOR APPROVAL.

***When the cost of the aluminum ramp and conventional ramp are comparable, then the aluminum ramp should be chosen due to the decreased maintenance costs and the lifetime usability.***

When the ramp has been approved, you will deliver the conceptual sketch of the NEW ramp (provided by RE&AT staff) and the ADA guidelines along with detailed ramp building instructions (provided by SAIL staff) to the vendor or volunteer group chosen to supply the ramp. The vendor or volunteer is responsible for building the ramp to the specific dimensions in the conceptual drawing in accordance with the ADA guidelines and the supplied building instructions. *[Note that volunteers cannot be used to build ramps for SAIL Waiver participants. They may only be used for Independent Living or Homebound clients.]* **THE WORK IS NOT COMPLETED AND THE BUILDERS**

**CANNOT BE PAID UNTIL THE RAMP HAS BEEN INSPECTED AND APPROVED BY SAIL and/or RE&AT STAFF.** Inspection must occur within 5 days of the service completion date.

***Ramp Repairs:***

Once the initial home visit is made for an **EXISTING** ramp, the RE&AT staff will provide either a dimensioned conceptual drawing or a list of needed repairs. He/she may provide an estimated list of materials to complete the repair (such as 7 5/4 x 8' deck board, a 1 lb. box of ceramic coated deck screws, etc.). In this case you must use a licensed building contractor (or volunteer labor in the case of Independent Living or Homebound clients only). The person must be licensed as a building contractor by the state, have proper credentials, and have the ability to deliver an accurate quote and site build or make accessible modifications. They must be on the STAARS vendor list as well as ADRS vendor list. *[Note that a DME vendor is not licensed as a contractor, and, therefore, you cannot use one to build a conventional ramp for Waiver participants. Additionally, you cannot use a third party through a DME or other contractor to build or repair the ramp. The work must be performed by the person presenting the quote. However, volunteers may be used to build ramps for Independent Living and Homebound clients.]* Once you make the decision to proceed with **repairs**, get a quote from the vendor. You are responsible for taking the drawings, etc., to the vendor for the cost estimate. The RE&AT staff is NOT responsible for providing cost estimates or quotes for materials. Any estimate s/he might provide when you are reviewing options, etc., is not a quote and cannot be used for authorization purposes. When you have the vendor quote, complete the "Prior Approval" page in SMILE and submit to the SAIL director and the Waiver program specialist in Montgomery. When they approve this, they will send it to Medicaid for approval. Do not proceed until you receive approval from Medicaid via the State SAIL office. (This step is necessary for Waiver participants only.) **DO NOT PROCEED WITHOUT PRIOR APPROVAL.**

You will deliver the conceptual sketch of the damaged ramp (provided by RE&AT staff) and the ADA guidelines along with detailed ramp building instructions (provided by SAIL staff) to the vendor or volunteer group chosen to supply the ramp. The vendor or volunteer is responsible for repairing the ramp to the specific dimensions in the conceptual drawing in accordance with the ADA guidelines and the supplied building instructions. *[Note that volunteers cannot be used to build ramps for SAIL Waiver participants. They may only be used for Independent Living or Homebound clients.]* **THE WORK IS NOT COMPLETED AND THE BUILDERS CANNOT BE PAID UNTIL THE RAMP HAS BEEN INSPECTED AND APPROVED BY RE&AT STAFF.** Inspection must occur within 5 days of the service completion date.

If the ramp needs repair but does not meet ADA compliance, it will be a decision of the RE&AT and SAIL staff as to what if any repairs will be made.

IF for any reason the plans from the RE&AT or SAIL staff changes, they **MUST** put the change in writing to the contractor.

If there is already a usage ramp at the home. SAIL will not assist with a secondary ramp.

## Policy on Bathrooms and Door widenings:

What do you do if your client needs a handicapped accessible bathroom? It is important to know that SAIL does not assist with the physical modification of the bathroom. What SAIL will do is assist in acquisition of a prefab roll-in-shower, the toilet and the modified sink. The participant will be responsible for the acquisition of building materials and labor to complete the job. SAIL staff will always refer the client name and demographic information to the RE&AT (Rehab Engineer & Assistive Technology) staff for bathroom assessment. This assessment does not indicate responsibility for assistance or financial responsibility for the modification. Because the home visit needs to include both you and RE&AT staff, get availability from RE&AT staff and make an appointment with the client that you can both attend. Don't forget to confirm the appointment with RE&AT staff.

Door widenings are often needed to be able to enter and exit a home. If the applicant/participant is unable to enter or exit the main door to their home or to their main living space, a door widening may be approved. Once you have decided that a door needs modification make the referral to the local RE&AT. They will determine if a door widening is necessary and how best to accomplish it.

**Medical Supplies** include devices, controls and/or appliances, specified in the Plan of Care, which enable individuals to increase their ability to perform activities of daily living, to maintain health and safety in the home environment, and to perceive, control, or communicate with the environment in which they live. All waiver medical supplies must be prescribed by a physician, be medically necessary and be specified in the Plan of Care.

The case manager must provide the participant with a choice of vendors in the local area of convenience.

Medical supplies do not include over-the-counter personal care items such as Soap/Body wash, Tooth brushes, Tooth Paste, Mouthwash, Vaseline, Alcohol, Peroxide, Witch-hazel, Lotions, Eye drops, Douche, Deodorant, Shavers, Shave cream, Vitamins, Aspirin, Band-Aids, Q-tips, Thermometers, Hand sanitizer, Decongestants, Cough Syrup, Sports creams/Biofreeze and other Over-counter Medications

Items reimbursed with waiver funds shall be in addition to any medical supplies furnished under the State Plan and shall exclude those items which are not of direct medical or remedial benefit to the individual.

Supplies are limited to \$1800.00 per recipient per year with a maximum of \$150.00 per month. Documentation for items purchased for recipient which is specific to the recipients.

Upon completion and receipt of the service the participant must sign and date the shipping form acknowledging receipt and satisfaction of the service and return it to SAIL for the provider to be reimbursed. Services will be authorized using the Authorization.

**Minor Assistive Technology** includes supplies, devices, controls, or appliances, specified in the Plan of Care, which enable individuals to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live. MAT authorizations include, but are not limited to: shower chairs, specialized cushions, alternating pressure pad and pump, specialized mattresses, over the bed table, shampoo tray, reachers, lift sling, transfer board, glucometer, green boots, urinal, ADL cuff-holders, elbow protectors or pads, hand splints, and specialized feeding utensils or additional medical supplies to maintain health and safety. All MAT supplies must be prescribed by a physician, be medically necessary and be specified in the Plan of Care. PA IS NOT REQUIRED FOR THIS SERVICE.

Providers of this service should be capable of supplying and training in the use of the minor assistive technology/device.

Items reimbursed with waiver funds shall be in addition to any MAT/devices furnished under the State Plan and shall exclude those items which are not of direct medical or remedial benefit to the individual.

MAT/devices are limited to \$500.00 per recipient per year. Upon completion and receipt of the service the participant must sign and date a form acknowledging receipt and satisfaction of the service and return it to SAIL for the provider to be reimbursed. Services will be authorized using the Authorization.

**Personal Emergency Response System (Installation)** PERS is an electronic device which enables certain individuals at high risk of institutionalization to secure help in the event of an emergency. The client may also wear a portable “help” button to allow for mobility. The system is connected to the person’s phone and programmed to signal a response center once a “help” button is activated. The response center is staffed by trained professionals.

The Installation of a PERS unit requires a prescription from the physician and a quote from the provider and it must be sent through the Prior Approval process (PA). Approval from the Alabama Medicaid Agency must be received before installation occurs. Once approved services will be authorized using the Authorization.

***A maximum one-time installation charge is allowed, once the recipient has had one installation, another one cannot be approved.***

Upon completion and receipt of the service the participant must sign and date a form acknowledging receipt and satisfaction of the service and return it to SAIL for the provider to be reimbursed.

**Personal Emergency Response System (Monthly)** PERS is an electronic device which enables certain individuals at high risk of institutionalization to secure help in the event of an emergency. The client may also wear a portable “help” button to allow for mobility. The system is connected to the person’s phone and programmed to signal a response center once a “help” button is activated. The response center is staffed by trained professionals.

PERS services are limited to those individuals who live alone, or who are alone for significant parts of the day, and have no regular caretaker for extended periods of time, and who would otherwise require extensive routine supervision.

Services will be authorized using the Authorization.

**Assistive Technology** includes devices, pieces of equipment or products that are modified, customized and used to increase, maintain or improve functional capabilities of individuals with disabilities. It also includes any service that directly assists an individual with a disability in the selection, acquisition or use of an Assistive Technology device. Such services may include acquisitions, selection, design, fitting, customizing, adaptation, application, etc. Waiver will pay for equipment when it is not covered under the regular State Plan and is medically necessary.

“Medically necessary” means that the service is directed toward the maintenance, improvement, or protection of health or toward the diagnosis and treatment of illness or disability. Therefore, waiver excludes those items which are not of direct medical or remedial benefit to the recipient. The business providing Assistive Technology services will possess the applicable business license.

Assistive technology may also be provided to assist an individual to transition from an institutional level of care to the home and community based waiver. Transitional Assistive Technology will be limited to hospital beds, Hoyer lifts, and/or wheelchairs (manual or electric). The service should not be billed until the first day the client is transitioned and has begun to receive waiver services in order to qualify as waiver funds. If the individual fails to transition to the SAIL Waiver, reimbursement will be at the administrative rate. This provision must be approved by the SAIL State Coordinator and the Medicaid designated personnel prior to submission through the Prior Approval System.

Assistive Technology must be ordered by the physician. The amount for this service is \$15,000.00 per waiver recipient over the waiver program lifetime. Any expenditure in excess of \$15,000.00 must be approved by the SAIL State Coordinator and the Medicaid

designated personnel. Once the PA is approved the authorization will be created and placed in draft to be issued.

Upon completion and receipt of the service the participant must sign and date a form acknowledging receipt and satisfaction of the service and return it to SAIL for the provider to be reimbursed.

Automobile lifts and automobile modifications are often requested. Lifts and modifications requests must be sent to the State office. There are several criteria that are addressed: Does the participant own the van, the age and condition. What public transportation is available? Cost of the request? Whether there has been other requests for Assistive technology? Depending on the answers to the questions, the state office will make the determination whether to proceed. The case manager will be notified of the disposition. If denied, the case manager will give the participant their appeal rights. If, approved to proceed, the case manager will refer the request to Lakeshore Drivers Evaluation. Lakeshore will determine what is required and will assist with quotes and documentation. This request must be submitted through the PA system.

**Assistive Technology Repairs** will provide for the repair of devices, equipment or products that were previously purchased through the waiver program for the recipient. The repair may include fixing the equipment or devices, or replacement of parts or batteries to allow the equipment to operate.

All items and services must meet applicable standards of manufacture, design and installation. The business providing these repairs will possess the applicable business license. They are also required to give a guarantee on work performed.

Similar benefits must be used prior to the waiver. The maximum amount for this service is \$2,000.00 per recipient annually. Services will be authorized using the Authorization.

Upon completion and receipt of the service the participant must sign and date a form acknowledging receipt and satisfaction of the service and return it to SAIL for the provider to be reimbursed.

**Personal Assistant Services** are for Waiver individuals who are competitive employed in an integrated setting at least 40 hours per month. PAS are a range of services provided by one or more persons designed to assist an individual with a disability to perform daily activities on the job. These activities would be performed by the individual if that individual did not have a disability.

An integrated work setting is defined as a setting typically found in the community which employs individuals with disabilities and there is interaction with non-disabled individuals who are in the same employment setting.

This service will be sufficient in amount, duration, and scope so that an individual with a moderate to severe level of disability would be able to obtain the support needed maintain

employment. The amount of time authorized does not include the Personal Assistant's transportation time to or from the participant's home or place of employment, but could include the transportation of the participant to and from the work site or in support of employment. It could also include essential shopping, eating and toileting, medication monitoring, entering or exiting doors on the job site.

Services will be contracted by a Service Provider Contract and services will be authorized using the Authorization.

IF THIS SERVICE IS USED FOR EMPLOYMENT, THE OA IS REQUIRED TO HAVE A SIGNED AGREEMENT WITH THE EMPLOYER STATING THAT IT IS ACCEPTABLE TO HAVE A PAS WORKER ON THE JOB-SITE.

#### **D. FACE-TO-FACE (CASE MANAGEMENT NARRATIVE)**

Upon entry into the waiver, the case manager periodically monitors the plan of care for each participant in the waiver program. Monitoring should be accomplished through monthly face to face contacts with the participant, responsible party, and /or knowledgeable other and if at all possible and with other agencies and providers included in the Plan of Care. At least one face-to-face visit is required each month with each participant. This face to face must take place inside the home. Drive-by, pop-ins and unscheduled stops are not face to face visits. An example: The case manager has finished up scheduled home visits and decides that since they are close in the area where Gray Day lives, they will drop by and make a home visit. Ms. Day is not home, the case manager completes a face to face and documents a missed visit. For the record this drive by is not a missed visit. Face-to-face visits must be scheduled in advance.

For the initial home visit after a participant has been approved for the waiver program the case manager has (5) five working days to make the first face-to-face visit. That initial visit must be made within 5 days to finalize the plan of care and choice of providers.

After the initial visit the face-to-face, visits should be scheduled at least the month prior to the visit, but must be scheduled at least 7 days prior to the visit. Recommended is a monthly schedule. The case manager would see the same set of clients every month on the first Tuesday; the same set of clients every month on the first Wednesday; the same set of clients every month on the second Wednesday. If the case manager does not use the recommendation then they MUST schedule the visit at least 7 days in advance.

The case manager only needs to schedule the day of the visit. The time can be left open to the entire day or can be 'before lunch' or 'after lunch'. Due to the nature of home visits

it is impossible to provide an exact time. The case manager will document on their Outlook Calendar what their specific home visit schedule will be and share it with the SAIL State office staff. “Busy” and “Free” on the Outlook calendar is not acceptable and against policy.

Home visits are to be scheduled on Tuesday, Wednesday and Thursday. Most of these visit should be scheduled toward the first two to three weeks of the month. The case manager must be in the office on Monday and Friday for meetings and administrative duties. Home visits and field work on Monday and Friday must be approved in advance by the SAIL Coordinator.

The case manager must go into the home for the visit. The case manager must see (lay eyes on) the participant.

A minimum of 15 minutes must be spent in the home, with the participant performing evaluation and case management in the home. The case manager must specifically address and document the following at monthly contacts:

- Participant’s current/health, safety and environment

- Appropriateness of the Plan of Care; and

- Waiver and non-waiver providers included in the Plan of Care are delivering the services that were committed.

- Participants are free from coercion, restraint, or seclusion.

In more road terms the case manager must document who is the responsible care giver and who is with the participant during the visit, along with their interaction. The case manager should observe the participant’s hygienic state, mental status and the condition of the home. The case manager should document any issues or concerns in the home, with the services, safety, or with accessing community resources. The case manager must address the plan of care with the participant assuring that the services are being rendered as documented in the plan and describe other services that may be needed and a proposal for obtaining those services. The case manager should inform the client of provider choice and ask if they are satisfied with their services. The case manager should obtain additional medical information including but not limited to change in physician, change in condition/medications, next medical appointment, and other follow-up information. The case manager should also discuss the participant’s emergency plan and make note of any changes from the previous emergency plan or responsible party.

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

In home environments that have been determined to be unsafe or potentially unsafe for the case manager, a monitoring strategy should be developed. This should be documented in a case note. **During these visits the case manager will assess health and safety, level of independence, freedom from restraint and coercion, and access to choices regarding services.**

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

The face-to-face forms must be signed by the participant or other person in the home present during the home visit. This visit form is documented into the CASE NARRATIVE of SMILE. The form is scanned into the electronic case file and the hard copy is place into the client file.

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

*Face-to-Face forms must be signed by the participant in Blue Ink.*

#### **E. MISSED VISITS**

Drive-by, pop-ins and unscheduled stops are not face to face visits and if the case manager does not see the client as a result of this type of unscheduled visit. It is NOT a missed visit. Face-to-face visits must be scheduled in advance per policy.

There are times when missed visits are inevitable. However, if it is a reoccurring situation with missed visits there will be an evaluation of the situation that is creating the missed visits. Case manager will notify each participant a minimum of 7 days prior to the home visit. It is recommended that the participant be notified on a home visit when the next month's home visit will occur. Once the visit is scheduled the participant must be home and present for the visit. If not, waiver services will be interrupted until the visit has been conducted for the month. Waiver services will not be reinstated until the required monthly face-to-face has been completed.

The only exceptions to this policy will be if the participant was hospitalized or in a medical institution prior to the case manager's arrival for the home visit. The hospitalization or medical situation must be documented in the case notes and case management narratives.

**F. CRITICAL INCIDENTS AND COMPLAINTS**

Case managers must report Critical Incidents within 24 hours of notification of occurrence or on the next business day to the SAIL State Office. The case managers are to complete the Critical Incident form and scan and email to the Waiver Program Specialist. There can be a CEI – Critical Event / Incident report, a CC/G – Client Complaint/Grievance, a PCC – Provider Compliance Complaint and/or a

The critical incidents which are to be reported are:

Abuse-Physical*	Abuse-Sexual*	Abuse-Verbal*
Death-Natural	Death-Unnatural*	
Exploitation	Fall	Fire
Injury – Major	Injury – Moderate	
Mistreatment*	Natural Disaster	Neglect

Other:

\*Must be reported immediately. Do NOT wait 24 hours to report.

The case manager is also responsible for reporting suspected abuse, neglect, exploitation to DHR or law enforcement. They are to document what happened, a brief explanation of what happened. Document what was done to address the situation. Document who was involved and who all was notified about the situation. The case manager is to describe any follow-up activities that were conducted to address the situation and if it was resolved, how it was resolved.

The case manager is responsible for documenting and investigating all complaints. Upon intake and at redetermination the case manager should provide the participant, responsible party, and/or knowledgeable others with the SAIL Rights and Responsibilities and the SAIL Complaint and Grievance Guide. The participant, responsible party, and/or knowledgeable others should be instructed to notify the case manager if services are not initiated as planned, if the participant’s condition changes or if changes are needed in the plan of care when problems are identified or reported. The case manager is responsible for investigating all complaints that any participant has.

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

## **G. PRIOR APPROVAL PROCESS**

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

The case manager should obtain a written prescription from the participant's physician.

The case manager should obtain a written price quote from the vendor of choice. When obtaining a price quote, the case manager must notify the vendor if the participant has Medicare or private insurance.

The vendor should file for comparable benefits and receive an Explanation of Medicare Benefits (EOB) which must become a part of the PA packet before payment is finalized.

On the initial PA page, the participant information will populate.

ICD 10 code from the SMILE disability will populate

Add the vendor information

If this is the first item requested, then it is a Certification, if this is the second item it is a Recertification/Continued Stay.

Enter date of the prescription

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

Press NEW under service item

The date of the price quote is the start date of service to be entered electronically on the PA. The end date spans a maximum of one year from the start date of the price quote. However, if the service can be rendered prior to the end of the fiscal year, the end date should be 9/30/00. The start date of the PA request, must match the date of price quote.

Choose the description of the services from the lookup list.

Enter the number of unit of the item(s) of request.

Enter the amount of the item(s) of the request for one unit.

Enter the total amount or cost of the item(s).

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

The case manager will enter the service on the participant Plan of Care.

Submit all the information to the Waiver Program Specialist for review. The Specialist will review all the corresponding information and request for Prior Approval (PA) number. Once HP has receives the PA electronically and it is accepted, a PA number will be electronically written to the request in the SMILE system. The Specialist will fax the prescription, the price quote, and any pertinent medical justification to the Prior Approval. The fax number is (334) 215-4140.

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

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

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

# Chapter 7

## Direct Service Provider Contracts

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

### **A. CONDITIONS FOR SERVICE PROVIDER PARTICIPATION**

In order to use a Direct Service Provider a Memorandum of Agreement (MOA) must have been initiated and signed by the provider agency, ADRS and Medicaid. This MOA stipulates guidelines for the provider participation.

Under this MOA the participant is guaranteed relief of any liability to pay any additional cost for service covered under the authorization provided by SAIL.

DSPs have a right to limit the number of Medicaid participants they are willing to serve; however, providers may not discriminate in selecting the Medicaid Waiver participants they will serve.

On-site quality assurance reviews of service providers will be conducted at least annually to determine compliance with regulations.

The DSP is required to maintain records that contain pertinent information on the personal care worker as well as on the participant.

### **B. CONTRACTING FOR PERSONAL CARE SERVICES**

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

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

The service contract must be specific and accurate, including the appropriate service. It must also include the number of units per day and days of the week for example 2 hours, 3 days a week or Not to exceed (NTE) 3 hours per day.

The hours of service should appear on the contract only if the hours indicate specific times which are essential to meeting the participants' service needs an example would be that services must begin at 8am. Unless specific hours are absolutely essential, rejection of a provider due to ability to provide requested hours is neither appropriate nor allowable. The provider must, however, be given the opportunity to accept or reject the hours. The case manager must ascertain that such specific hours requested are required and not simply desired by the participant. Desired hours may, of course, be negotiated with the participant and with the provider during the provider's initial contact.

The DSP initial home visit must be scheduled as to accommodate the participant and/or family, the case manager and the proposed personal care worker.

### **C. VERIFYING IMPLEMENTATION OF CONTRACTED SERVICES**

Case managers must contact the participant or his/her responsible party within ten (10) working days after the service authorization and or the initial enrollment visit to ensure services are implemented and to review participant/agency responsibilities. This contact may be made by telephone or home visit. Follow-up contact with the provider(s) may be necessary to resolve questions or problems with contracted services. Regular contact must be maintained with the providers of waiver services.

### **D. CHANGES IN SERVICES WITHIN A CONTRACTED PERIOD**

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

A temporary change (increase in the number of units or change in authorized days) can be made for a period of thirty (30) calendar days. Any change exceeding the 30-day calendar days must be considered permanent for the purposes of the service contract. A verbal approval to providers may be given for a temporary change in the number of units or days. Within 3 days, this change must be followed by completion of a revised service contract, which must be sent to the provider. Temporary changes should be noted on the form as a temporary change with the authorized start and end dates. The services will then revert back to the authorized service schedule as indicated on the latest service contract.

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

**E. INTERRUPTION OF PCW SERVICES AND MISSED VISITS**

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

Participant enters the hospital or institution (i.e., rehabilitation center, nursing home) for a temporary stay; or

Participant is in the community but chooses not to receive services temporarily (i.e., participant has a doctor's appointment, goes out of town, declines substitute PCW).

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

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

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

Interruption in service reported by the participant, responsible party and/or knowledgeable other (excluding calls received from providers), must be recorded in a case note. This includes phone calls received from the participant, responsible party, and /or knowledgeable other, as well as information obtained by the case manager during the monitoring process.

**F. DIRECT SERVICE PROVIDERS- INITIAL AND NURSE SUPERVISORY VISIT REPORTS:**

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

After the initial visit has been made, the vendor will be responsible for the supervisory visit due every sixty (60)-days. A RN or LPN must perform the supervisory visits. The original of the supervisory visit report must be forwarded to the SAIL Case Manager with in ten (10) days of the date of the visit. Failure to provide the documented visit will result in loss of payment from the SAIL program and repetitive non-compliance will result in loss of business with SAIL. Each participant must have a supervisory visit performed every sixty days with no exceptions. These supervisory visits must be scheduled. Drive-bys, pop-in, unscheduled visits are not supervisory visits and if missed are Not missed visits.

Any missed visit should be documented in the participant file and another visit scheduled within five (5) days. All supervisory visits will be performed by the RN/LPN in the participant's home. Phone calls are not supervisory visits and will not be accepted. The participant or a family member must sign the report indicating the visit was made in the home.

# Chapter 8

## Recipient Update and Review

### **A. SERVICE INTERRUPTION**

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

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

When a participant enters a long term care facility or a nursing home, the waiver case must be closed on the date prior to the date of LTC/nursing home admission. If the participant returns home, a readmission to waiver is required.

### **B. ANNUAL REDETERMINATION FOR SERVICES**

To remain eligible for Waiver services, the participant must be re-evaluated each year. This process should be initiated 90 days prior to the redetermination date or a minimum of two (2) months prior to eligibility end date.

To remain eligible for waiver program the applicator/participant must meet all medical and financial criteria. They must require a minimum of at least one waiver service.

The case manager must assess whether the participant is free from coercion or restraint, and is not being restricted by others or the environment from fully engaging in service provision.

The case manager is responsible for the completion of HCBS and for obtaining the qualified medical provider signature.

At each redetermination the following forms must be discussed with the applicant/participant and they must be signed and dated.

Medical Supply List and Medical Supply Participant Understanding

Waiver Responsibilities

Complaint and Grievance Guide

Confidentiality Release

DHR notice

Email, Text and Fax Form

Notice of Privacy Practices

Participant Choice Documentation

Vendor Choice Form

Once it has been submitted in SMILE, the original HCBS will be submitted to the SAIL Nurse for eligibility determination. Redeterminations **must** be submitted to the Nurse prior to the (8<sup>th</sup>) eighth of the redetermination month. It is the case manager's responsibility to ensure that the redetermination is complete and accurate without errors.

Once approved by the Nurse, the application will be electronically transmitted to Medicaid for approval for the participant's new waiver year. The application cannot be transmitted to Medicaid prior to the eligibility month.

### **C. EARLY REDETERMINATION OF ELIGIBILITY**

Request for an early redetermination must be approved by the SAIL Program Staff at least 30 days prior to the month with the new redetermination date. Written consent of the participant is required. This consent will state the early redetermination has been discussed with the client and that he/she is in agreement with early redetermination.

Approval of this request will be dependent on the benefit to the participant and the program.

If approved the new end date will be the last day of the month with the new redetermination date to begin on the same day of the month. SAIL Program Staff must complete LTC Request for Action Form along with the consent of the participant and submit to the Medicaid designee.

Alabama Medicaid Agency will enter the new begin and end date and return the LTC request Action Form to the SAIL State Office. The new dates will be transmitted through the LTC notification software.

### **D. READMISSION**

If eligibility has lapsed before a redetermination has been completed the application is considered a readmission, which establishes a new eligibility period. The same medical criteria and financial criteria must be met. The same application process must be followed.

Re-admission after hospitalization over one calendar month or closure due to institutionalization the applicant must request readmission. The application process will be the same as an initial assessment and requires that the participant meet the medical and financial admission criteria.

If this readmission was a result of a hospitalization, the case manager will provide supporting documentation (medical records) of an unstable medical condition that would

indicate an episode of an acute illness and active treatment within the past 30 to 60 days (relative to checking G under Admission Criteria which reads Observation of unstable medical conditions required on a regular and continuing basis that can only be provided by or under the direction of a registered nurse).

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

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

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

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

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

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

#### **E. TRANSFERS WITHIN SAIL**

##### **County to County within the service area.**

When a participant moves from one county to another county within the same service area and there is no change in case manager, the following must be documented.

Update the personal information data page in SMILE to include the driving directions to the new location.

If the participant also changes physicians, a new HCBS must be completed.

The case manager must instruct the participant/family to notify the Social Security and the Medicaid Office of the address/telephone number change.

The case manager must re-assess the home and living situation to ensure that services are still appropriate.

At the time of the participant's annual re-determination, ensure that the correct county code is used.

## **County-to-County outside of the original service area.**

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

Notify the new case manager as soon as the client notifies them of the pending move.

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

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

Make a home visit as soon as the participant has arrived in the new residence.

Interview participant, verify continued eligibility, and access services required.

Complete new plan of care and arrange for services

Complete new HCBS-1 forms if the participant has obtained a new physician.

The case manager must instruct the participant/family to notify the Social Security and the Medicaid Office of the address/telephone number change.

At the time of annual redetermination the case manager must assure that the correct county of residence is in SMILE. SMILE will update the prior control number to indicate the new county code.

For those who have financial eligibility determined by the Alabama Medicaid Agency, a notification will be generated about the transfer and sent to the transferring area office.

The receiving case manager will be responsible for making all changes to the Personal Information data page.

## **Change in Case Managers**

When there is a programmatic decision to change case managers the following procedures will be followed. The transferring case manager and the new case manager will schedule a home visit together in order to make as smooth transition for the participant as possible.

The receiving case manager should provide the participant with all their contact information and discuss the home visit policy and schedule.

The receiving case manager should interview the participant, verify continued medical and financial eligibility, and access to services required.

Complete new plan of care and arrange for services if required.

A Case note should be placed in the file from the receiving case manager stating that the case was transferred from case manager XX to them on Date.

## **F. WAIVER-TO-WAIVER TRANSFER**

It is possible to transfer from one Home and Community-Based Services Waiver program to another. Transfers occur when the services under one program better meets the needs of the participant than the program they are enrolled under. This transfer may occur only if the participant meets all eligibility requirements and program perimeters and the services provided under the new waiver are appropriate.

The high cost for an individual's current waiver services is not a valid reason for an individual to be transferred to a different waiver. The only appropriate reason to transfer an individual to a different waiver is for the individual to be able to access services on the new waiver that are not available on their current waiver. The services of the new waiver must be vital to the individual's stay in the community. The client's condition must be such that without the services of the new waiver, the individual will be institutionalized. There must be documentation in the medical record to support the transfer from one waiver to another waiver.

Slots left vacant by a transfer to another waiver cannot be filled again until the beginning of the new Waiver year.

If a participant elects to transfer from one Waiver to another Waiver there must be very close coordination between the case managers of both Waiver programs.

### **Transferring to SAIL**

If a participant wants to transfer to the SAIL waiver, the participant must contact their current waiver provider and request their case be transferred. The participant will provide the case manager the information for the current waiver including the case manager name and number. The SAIL case manager will contact the serving waiver staff and request a transfer. The SAIL case manager will request an email address and will document the transfer request in writing. A date for transfer will be agreed upon by both waiver programs.

When the case is being transferred to SAIL. The case manager will make a home visit and assess the applicants/participants qualifications for the SAIL waiver. If the applicant meets the standards for enrollment the initial application will be completed. Transfer will be documented on the HCBS and in the application narrative.

The closing waiver will close on the last day of the month. The receiving waiver will open on the first day of the next month. For example: E&D would close on October 31st and SAIL would open on November 1.

If the participant receives his/her Medicaid as a result of a District Office financial determination, the District office must be notified by the (15th) of the month of the pending transfer. This is done by submitting a slot confirmation form (approved by the Nurse) with a notation – transfer from XYZ waiver to SAIL waiver, and the date of transfer noted. This forms should also be emailed to the Waiver Program Specialist.

If the participant receives his/her Medicaid as a result of Social Security SSI benefit, the Waiver Program Specialist should be notified by email that a transfer is pending.

The Waiver Program Specialist will complete an LTC form, on the date the transferring waiver closes the case and email to the Alabama Medicaid Agency with notation “transfer case has been submitted”. This coordination will help ensure a smooth transition and avoid unnecessary problems or delays in the transfer process.

Once the case is transferred the SAIL case manager must verify eligibility through the MSIQ. The case manager has (5) days to make an initial visit and initiate services.

### **Transferring to another waiver**

If a participant wants to transfer to another waiver, the case manager will gather the receiving waiver case manager information from the participant. The SAIL case manager will have the participant sign a release to be able to specifically talk with the receiving waiver program. The SAIL waiver case manager will call the receiving case manager and ask what information they require for transfer. The SAIL case manager will request an email address for the receiving case manager. A date of transfer will be agreed upon and SAIL case manager will send an email documenting the case closure will occur on the agreed upon date. The SAIL waiver case manager will close the case on the agreed upon date.

Again, for Waiver-to-Waiver transfers, always terminate services on original Waiver on the last day of month and start service delivery on new Waiver on the first day of the following month.

## **G. REINSTATEMENTS**

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

- Once the participant is admitted to the nursing home, the waiver case must be closed on the date prior to the date of LTC/nursing home admission.
- A reassessment must be completed and services resumed within ten (10) days from the nursing home discharge date. The case manager must conduct a face to face visit before

services are resumed. The District Office must be notified by the 15th day of the month of the discharge date. Those who miss the 15th deadline date must wait until the next month to return home and have waiver services reinstated.

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

- The full HCBS-1 application must be updated, with the exception of the Admission and Evaluation Data page (Medical form)
- The HCBS-1 Plan of Care start dates must be updated for all services-including case management services
- The course of events related to the nursing home admission and the discharge should be clearly documented on the HCBS-1 Application Narrative to reflect nursing home admission date, nursing home discharge date and the date the waiver services were ended and resumed. It is understood that in some instances the family may not notify the case manager upon the participant's discharge. The case manager will resume services as soon as possible, but no later than 10 days after notification occurs.

In the event that the participant's nursing home stay exceeds the 100 days, a re-admission to waiver is required.

If the participant's waiver eligibility expires during the time of the nursing home stay, but during the waiver year, a re-admission is required.

If the participant's eligibility has expired and a new waiver year is underway, the person will be placed on the referral list and an application taken as a slot becomes available.

## **H. TERMINATION OF SERVICES**

All the reasons, issues and concerns for the termination of the waiver program must be fully, completely and consistently documented in case notes and in case management reviews. The case must be discussed and approved by the SAIL Coordinator. The participant and/or primary caregiver must be notified by certified letter of the reasons for the closure and their appeal rights.

A waiver case may be closed for any of the following reasons:

1. \*Conduct which adversely impacts the program's ability to ensure service provision or to ensure the participant's health, safety, and welfare.

Ex.: Evidence of sustained alcohol or drug abuse.

2. Closed to SAIL-Homebound case.

Ex.: Participant chooses SAIL-Homebound over Waiver.

3. Transferred to another Waiver (i.e. MRDD, E&D).
4. Death
5. Financially Ineligible
6. Institutionalization – Nursing Home (Closure must occur within 48 hours of admission) (Date of closure is the day prior to the date of admission).
7. Hospitalization for more than one full calendar month.  
A full calendar month is defined as from the first instant of the month throughout the last instant of the month. For example, if a participant enters a facility before 12 a.m. (midnight) on the 1st day of April and remains throughout the end of April, then closure must occur April 30th. However, if the participant enters a facility after 12 a.m. (midnight) on April 1st or on any other day in April, closure must occur on May 31st. If the participant remains hospitalized or institutionalized for a full calendar month, the case must be closed to Waiver effective no later than the last day of the full calendar month period and the services, which were previously suspended, must be terminated. The case must be terminated. In order to facilitate a re-admission for the participant expected to return to the Waiver, the case manager will document discussion of discharge plan with the hospital social worker or RN and primary caregiver of the participant's impending discharge.
8. Medically ineligible – Participant no longer meets medical admission criteria. Qualified medical provider refuses to sign the HCBS application.
9. No longer desires services
10. No longer eligible because they are no longer a resident of the State of Alabama.
11. Non-compliance with Plan of Care. If a participant and/or primary caregiver refuse to cooperate and all alternatives have been exhausted, the individual may be terminated.
12. Out-of-state for 60 days. If a Waiver participant leaves the State, all services must be placed on hold. If the participant continues to remain out-of-state after 60 calendar days after the date of departure, the waiver case must be closed and all services terminated.

Any exception to this rule must be approved by the Alabama Medicaid Agency in advance of the participant leaving the state and there must be documented proof that the applicant/participant intends to return to the State.

13. Physical Abuse. This may be physical abuse to self, providers or Waiver staff.
14. Refusal to Cooperate. Repeated refusal to cooperate with providers and/or case managers.
15. Verbal Abuse. This applies to abuse directed to providers and/or Waiver staff.

When closing a case that has Medicaid due to 300%, the case manager must also notify the local District Office once the participant has received and acted on their appeal rights.

Once a client is terminated for services, readmission for services are on a case by case basis and at the discretion of the State Office.

However, if the case was terminated for cause such as verbal abuse, physical abuse, refusal to cooperate, non-compliance, the program reserves the right to decline readmission to SAIL waiver. The applicant/participant will be provided with his/her applicable appeal rights.

If an applicant has requested waiver services from SAIL and was terminated from another waiver, the case manager must notify SAIL State office immediately. The waiver program specialist will research this termination to determine if the applicant is eligible for services through Medicaid. The determination will be sent to the case manager for their records.

# Chapter 9

## Billing and Accounting

All billing should be received in the District SAIL offices no later than the 10<sup>th</sup> of the month of the preceding month of services.

### **A. MEDICAL SUPPLIES/BILLING:**

The waiver states medical supplies are necessary to maintain the client's health, safety, and welfare and to prevent institutionalization. Supplies reimbursed with waiver funds shall be in addition to any medical supplies furnished under the State Plan. State Plan must be billed first. All waiver medical supplies must be prescribed by a physician, be medically necessary and be specified in the Plan of Care. From time to time SAIL clients may need more medical supplies items than are provided under the Medicaid State Plan, i.e. catheters, legs bags, gloves. For those items to be paid with waiver funds, SAIL case manager must have justification why these additional supplies are needed. SAIL should never pay for medical supplies covered under the Medicaid State Plan without these justifications.

The waiver case manager is to review each bill to ensure that the participant received the items specified under the plan of care and to assure that disallowed supplies were not obtained. It is the case manager to contact the medical supply company and discuss items which were not approved. The case manager is not to pay for unapproved items.

The bills should be date stamped in to the District office. The case manager should review and approve the billing within 5 days of receipt. To approve a bill the case manager initials and dates the bottom of the bill with red ink.

### **B. PERSONAL CARE**

The case manager is to review the PCW timesheets and the billing statement, as well as the supervisory report and missed visit reports to ensure that the services are being rendered as ordered. The DSP has the responsibility to appropriate and correctly bill for the services that they provide. However, no matter how diligent the DSP is with billing, errors do occur.

The case manager has the responsibility to reconcile the timesheets and the bills from the DSP once they receive them. The case manager is responsible for correlating the timesheets, with the bills, with the missed visits, with the nurse supervisory visits to the DSP contract they created and the authorization. If all the submitted billing information is correct and it is billed to the specifications of the DSP contract and the authorization.

The bills should be date stamped into the District office. The case manager should review and approve the billing within 5 days of receipt. Case manager approve by signing their initials in red and dating the bottom of the billing sheet.

What constitutes a personal care service improper payment? An improper payment is any payment that should not have been made. Such payments include:

- Claims paid without the supporting documentation.
- Services provided and billed that are not eligible for reimbursement.
- Services provided without required supervision.
- Services provided by unqualified personal care workers.
- Personal care payments made for care provided while a beneficiary was in an institution or hospital.

Bills or portion of bills may be disallowed. Bills or days of service are disallowed when:

- The participant and/or the worker did not sign the day of service.
- When the time on the timesheet does not match that of the billing record.
- When the time is billed for more or for less than the billing record.
- When personal care services are not marked on the time sheet.
- When the timesheet is not legible.
- When the DSP nurse reviewer did not approve.
- When the missed visit is billed as time provided.
- When the supervisory visit did not occur within the 60 day time frame.
- When time was billed and the participant was in the hospital or did not receive the service.
- Services are billed prior to the service contract or authorization.

If the case manager suspects that the timesheet have been forged they are to call the SAIL Coordinator or the Waiver Program Specialist and report immediately. If they suspect that the supervisory visits are copies and the supervisory visits are not occurring, they are to call the SAIL Coordinator or the Waiver Program Specialist and report immediately.

Services not eligible for reimbursement include:

- Providing services to a person who is not eligible for Medicaid.
- Services that are not in the plan of care.

Providing services for other members of the household other than the participant.  
Services by the worker without verified qualifications.

### **C. MINOR ASSISTIVE TECHNOLOGY**

These services tend to be one time services to meet specific needs. Once the service is provided, the participant is to sign a receipt of service and/or satisfaction form. Many items under minor assistive technology once delivered and accepted by the participant cannot be returned to the medical supply due to State regulations. As a result is the minor assistive equipment has been delivered, SAIL is obligated to purchase the equipment. If the participant is unable to use the equipment and the medical supply company will not take it back the case manager will provide the equipment to the Independent Living Specialist. The case manager will be responsible for obtaining a signed receipt form that the participant did receive the equipment. If they were satisfied with the equipment then they must sign that they were also satisfied. It is the case managers responsible for assuring that the form is signed whether that means mailing the form or making a home visit and having it signed. The form must be signed within (10) days of the delivery of the service. The vendor is to be paid within ten day of the delivery of the service.

### **D. ASSISTIVE TECHNOLOGY AND REPAIRS AND MAINTENANCE**

For repair and maintenance over the 2000.00 that were PAed to the Medicaid System, the case manager should secure an EOMB (Explanation of Benefits) from the vendor, prior to final payment. Explanation of benefits should also be secured if the recipient has other insurance. The case manager is responsible for assuring a receipt of delivery/satisfaction form is signed whether that means mailing the form or making a home visit and having it signed. The form must be signed within (10) days of the delivery of the service. The vendor is to be paid within ten day of the delivery of the service.

Since assistive technology services must be PAed to the Medicaid System the case manager must secure an EOMB (Explanation of Benefits) from the vendor, prior to final payment. Explanation of benefits should also be secured if the recipient has other insurance. The case manager is responsible for assuring a receipt of delivery/satisfaction form is signed whether that means mailing the form or making a home visit and having it signed. The form must be signed within (10) days of the delivery of the service. The vendor is to be paid within ten day of the delivery of the service.

### **E. PERSONAL RESPONSE UNIT**

Once the personal response unit is ordered and placed in the home, the case manager will be responsible as part of the monthly face to face ensuring that the participant has the

PERS unit and that it is in working order. The bills should be date stamped into the District office. The case manager should review and approve the billing within 5 days of receipt. Case manager approve by signing their initials in red and dating the bottom of the billing sheet.

#### **F. FRAUD WASTE AND ABUSE**

Improper payments doesn't always involve fraud, waste and abuse. Simple, infrequent billing mistakes, may just be human error. When billing errors occur, the provider is required to disclose the error and return the payments received for those errors.

Sometimes providers deliberately defraud. Fraud is defined as 'the intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person.'

Fraudulent billing can include billing undocumented, ineligible, unsupervised, unauthorized services. It can be billing for services that were substandard, uncompleted, or never rendered.

# Chapter 10

## Case Storage and Filing

### I. CASE FILES

SAIL is making a concerted effort to have a paperless case management system. In those efforts the following recommendations have been made for the proper documentation storage and filing of participant information.

ALL application documentation that has original signatures from the applicant/participant, and/or physician, and/or SAIL staff will be scanned into the electronic participant file and then placed into a participant hard file. This includes the HCBS, releases, right and responsibilities, etc.

All other information will be scanned into the electronic participant file. This includes third party information, billing, correspondence, miscellaneous information, etc.

The Naming Guide follows: These are examples

<b>Document Name</b>	<b>Title in Document Images</b>
Agency-Based Voter Registration	Voter Registration/Voter Application
Application for Services and Information Release Consent	Application for Services
Release of Info for Job Placement	ROI for Job Placement
Medical History & Questionnaire	Medical Hx Questionnaire
Notice of Privacy Practices	Notice of Privacy Practices
Email, Facsimile and Texting Consent	Email, Fax and Text Consent
Faxes of Release of Information sent	ROI faxed (name of recipient), for example: ROI faxed Bob Jones PhD/Grayson Assoc ROI faxed Lawson State ROI faxed John SmithMD/Nephrology Asso

[Note: If you fax a ROI, always keep/scan the faxed so we can better follow-up if records don't come in as expected.]

Release of Information to get records      ROI (name of recipient); don't describe what's been requested as that is detailed on the release form itself, for example:

ROI St Vincent's Birmingham

ROI Jefferson State Community College

ROI Mark Middlebrooks MD

ROI Paul Scalici MD & Seale Harris Clinic

[Note: if you are mailing a ROI, before scanning write the mail out date and initial it so we can better follow-up if records don't come in as expected. If you fax a ROI, always keep/scan the faxed ROI as noted above so we can better follow-up if records don't come in as expected.]

Release of Information to share info      ROI to (name of person or organization information is to be shared with) example, for parent or significant other state ROI to parents (Bob & Sue Jones). For Disability Determination or other agency use ROI to (name of agency) and abbreviate as needed for allowed space; do not use commas, periods, or colons when labeling documents of any kind as they just take up unnecessary space.

Appointment letters      Appointment for SAIL Intake, Appointment w/BRC, Appointment @ UAB School of Optometry, Appointment w/William Meneese PhD, Appointment w/Deborah Boswell, and so on (abbreviate as needed such as Appt w/Wm Meneese PhD)

Referral letters or memos      Referral to BRC, Referral to UCP for Steps, Referral to UCP for Milestones, or Referral to Easter Seal for Steps, Referral to Triumph for Milestones, Referral to Workshops for Steps, Referral for benefits counseling, etc.

Reports of services or evaluations      Progress report (month/year covered in the report) (name of organization). Three elements: (1) What is it, (2) when is it [unless Date of Document covers the when for a single date, as opposed to a multi-week period like a progress report], (3) who it's from, in that order. For example:

Progress report Oct 2013 Triumph

VE report Feb 2016 Lakeshore

Employment report Feb 2016 Easter Seal

Psychological evaluation Wm Meneese PhD

Psych eval William Meneese PhD

Speech evaluation Deborah Boswell

RTS Evaluation Bynum Duren

OT Evaluation CRS

Nurse Supervisor Visit Dana Tidwell

Authorization claims A#(authorization number) and type of payment (Full, Partial or Cancelled). Include item number for partial payments, if there is more than one item number. Scanned documents should include signed grid copy of the authorization as well as invoices. [Note: It is not necessary to scan partially paid claims but you may for your own convenience. Final paid claims and all invoices are filed in the financial folder for that fiscal year. Authorizations cannot cross fiscal years.] For example:

A#123456 PPay Item 2

A#235467 FPay

A#345678 Cancel

Gas receipts A#(authorization number) gas receipts (include dollar amount of receipts). For example: A#456789 gas receipts \$50

Medical records Records (name of provider as shown in ROI) such as Records VA Medical Center, Records Pedro Guzman MD, etc.

Transcripts Transcript (name of school)

## The INDEXING GUIDE

Once you have selected VRCASEFILES as the document type the indexes will appear for you to complete. This is currently the only index choice for document types.

Document Group: This is the CASELOAD ID for this particular case. If you key in the CaseID, this will be completed for you. NOTE: if this does not appear correctly then check your CaseID and make sure you have this correct.

CaseID: This is the CaseMasterID which is utilized by the ADRS.net system for this particular case record. You can configure your Caseload Browse Column 4 to show Case ID or you can retrieve it from Personal Information or many other SMILE pages.

ParticipantLName: Last Name for the individual – this is filled by the completion of CaseID

ParticipantFName: First Name for the individual – this is filled by the completion of CaseID

DateOfDocument: Enter the date for the Document. This is not a required field but helpful in looking for information at a later time. For documents

having multiple dates (such as medical records) use the most recent date

VRCFDocumentCategory: There are six categories to help in locating a stored document. These are:

**Intake/Eligibility** – Any information regarding the intake or eligibility information for a participant. (i.e. medical information, signed application form, or other documents completed as part of the intake)

**Services/Reports** – Any information regarding the planning or reports of provision of services for a participant. (i.e. Signature Page of service plan, hand-written plan with signature, nurse supervisor reports, RTS assessment, PT/OT reports, Community Rehabilitation Programs (CRP), etc.)

**Financial/Receipts** – Any information regarding financial information. (i.e. Social Security verification, authorization claims & invoices, vendor quotes, receipts for authorizations)

**Employment/Work** – Any information regarding employment or work. (i.e. Resumes, job descriptions)

**Closure** – Any information regarding closing of a case. (i.e. Closure letter)

**Correspondence/Releases/Misc** – Any information regarding correspondence completed on the record, Releasing of information, and miscellaneous information necessary to the case. (i.e. Letters, Fax cover sheets & reports, Release of information, Prescriptions, etc.)

VRCFDocumentName: Descriptive name of document or give document title. Be specific but minimize any abbreviations used. (See *Naming Guide for Document Images*)

Once you have completed all the indexes and verified that you have completed the indexes accurately according to the document then select the OK Button at the bottom.

You will be asked if you are sure you are ready to commit this document. Indicate YES if you are or NO if you wish to go back and change something. The document will then be saved to ImageQuest.

(See next page for example of documents under the categories) **Case File Indexes are in bold** - The list is NOT inclusive just items encountered thus far.

<b><u>Intake/Eligibility</u></b>	<b><u>Services/Reports</u></b>	<b><u>Financial/Receipts</u></b>
Applicant Rights Form (IL, VR, etc.) Consultations (i.e. Neuro/Psych/Medical) Medical/Psychological Records Signed Application Forms (IL, VR & Waiver) Voter Registration Vendor Choice Forms Nurse evaluations Referral form HCBS Medical Supplies Participant Choice Declaration of Citizenship & Lawful Presence VR Notice of Privacy Practices Waiver Rights and Responsibilities Complaint and Grievance guide Confidentiality Release DHR Notice Email, fax, text form Redetermination HCBS & all forms IL Application & Application worksheets Medical Specialist Forms	Face to Face Care Plans Accommodation Verification Form RN/LPN Supervisory visit College Training Agreement form Critical Incident report CRP Reports College/high school Grades/Transcripts Service plan/IPE showing plan # & signature Handwritten Service plan/IPE "Signed" Job Coaching Reports SAT/ACT Results Special Needs ID & Request Form	Authorization grid page with Invoices, Receipts and signature Sliding Scale Form Health Insurance Claim Form Insurance Verification Form/information IRS Letter of Non-Filing Status and/or Tax returns PERS bills DME bills Missed Visits SSA Verification Statement of Financial Status FAFSA Letter/Summary Award Inquire (Pell Grant) Form 204 Home Community Based Medicaid Application Homebound Financial Eligibility Personal care time sheets Personal care bills APS Employment Application packets, Timesheets & Approvals Equipment release forms EOB
<b><u>Employment/Work</u></b>	<b><u>Closure</u></b>	<b><u>Correspondence/Releases/Misc</u></b>
Job Readiness Forms Job Search/Details Print out of Job Description Resume Ticket to Work Form	Letter to discontinue services Closure Letter	Release of Information/Letter (ROI) Participant Satisfaction Birth Certificate Correspondence from Vendors Referral to Seating clinic, VR, CRP, clinics, psychologist, RTS, etc. Dr's Sign-In Sheet Fax cover sheets & reports Interoffice Memos Letter – who to or who from Memos – who to or who from Notes from Consumer Emails from consumers or vendors (unless copied to case note) Seating clinic referral Admission/Termination memo from CRPs Request of Verification of Services Social Security Card Worksheets

# Chapter 11

## Quality Assurance

### Audit Procedures

#### **A. INTRODUCTION TO QUALITY ASSURANCE MEASURES**

SAIL is committed to ensuring that services are provided at the highest quality. SAIL is committed to ensuring that services are provided at the highest quality. Quality is evaluated through case documentation, client reports, Medicaid reviews, case management reports, and third party observations.

In addition to Quality Assurance reviews performed by the Alabama Medicaid Agency, the components of the SAIL-Homebound Quality Assurance program are: Quality of services provided and the scope of services available to the participant.

The review of case documentation, is designed to assure:

- 1) Statewide program consistency
- 2) Quality of services provided
- 3) Scope of services available to the participant
- 4) Timeliness in provision of services
- 5) Cost efficacy and efficient

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

- SAIL State office staff will review 2% random selection of participant cases (hard files) every 60 days.
- SAIL State office staff will perform a SMILE review of 2% randomly selected cases every 60 days.
- Annual case manager review by SAIL Director or Program Specialist.
- 2% of each case managers cases will be reviewed and a participant home visit will be made by the SAIL Office staff annually.
- 5% of participants will be called by State office staff for a satisfaction survey addressing case management and other services.

- Random Monthly Retro reviews requested by the Alabama Medicaid Agency. Reviewed by the State office and forwarded to Medicaid.

QA Documentation:

**Eligibility:** MSIQ Screen will be checked monthly and documentation in case file.

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

**Justification of need:** The case manager will state the reason for the participant's need of a service as outlined on the plan of care. An example: Mr. Box has a diagnosis of quadriplegia leaving him in need of personal care assistance with activities of daily living and specialized medical supplies for the protection of skin integrity.

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

**Satisfaction:** The case manager will describe in the narrative what the participant's/families level of satisfaction with the vendors and services that they receive. An example: Mr. Box stated that the personal care means he can get a bath every day. He reports that his worker is great.

**Health and Safety:** The case manager will describe whether or not safety needs are being met (family, other health care agencies, friends). Health and safety will be included on the plan of care as a non-waiver service. If the participant lives alone, document health and safety supports that are in place during the time alone, especially when the personal care worker leaves the home. In addition, document that the participant's home supports his or her ability to access the community and is not presumed to be institutional.

**Family support:** The case manager must identify family support. They must state the level of involvement of the family members. If the personal care worker happens to be family, an additional justification must be present as to why the personal care worker is a family member.

**Missed visit attempted:** If a missed visit occurs, the case manager will document that it was a scheduled visit, the reason it was missed and when a follow up visit may occur.

**Documenting Choice:** The case manager will document in a case note and in the narrative section of application narrative that the participant was provided vendor choice. The case manager will provide the participant at a minimum at redetermination time, a vendor choice form for the participant to sign. The participant will be afforded the ability to change vendors at any time with notification to the case manager.

**Complaint/Grievance Log:** SAIL waiver offices will keep a file in each local office to record any complaint or grievance and the action taken to resolve the issue. Case managers are to investigate all complaints logged in the local office immediately. A report of that investigation should be noted in a case note and as part of the log. The complaint and the steps taken to resolve it will be fully and accurately documented in the log and in a case note. The State office will also be responsible for documentation any complaint or grievance that makes its way to State office personnel.

The case managers are required to send the complaint log to the state office by the 5<sup>th</sup> day of the month following the end of the fiscal quarter. The end of the fiscal quarter occurs December 31, March 31, June 30 and September 30.

From the reports received from the field offices a report will be generated and sent to the Alabama Medicaid Agency Long Term Care Quality Assurance division.

## **B. INTERNAL AUDIT PROCEDURES**

SAIL State office staff will review 5% random selection of participant cases (hard files) every 60 days. These audits may be scheduled or unscheduled. All hard files will be kept current and up-to-date following the policy and procedures. A feedback to the case managers will be provided addressing the quality of their work, adequate justification of the services provided to their clients, timeliness of the work product, completeness and accuracy of documentation and areas for improvement.

SAIL State office staff will perform a SMILE review of 5% randomly selected cases every 60 days. These audits may be scheduled or unscheduled. All SMILE computer files will be kept current and up-to-date following the policy and procedures. A feedback to the case managers will be provided addressing the quality of their work, adequate justification of the services provided to their clients, completeness of work performed, completeness and accuracy of documentation, timeliness of their work product and areas for improvement.

Annual case manager review by SAIL Director or Program Specialist to review performance during the year. Review of case work to ensure that the case manager is adherence to the policy and procedures and the participants are being provided with the services in a concise and timely manner.

5% of each case managers cases will be reviewed and a participant home visit will be made by the SAIL Office staff annually. The home visits will be scheduled with State office staff. These visits may be in conjunction with the case manager or they may be visits performed during an alternative time other than when the case manager is present.

5% of participants will be called by State office staff for a satisfaction survey addressing case management and other services. This telephone survey will collect data such as;

- Does the case manager schedule home visits with ample notice?
- Does the case manager visit each and every month?
- Does the case manager come in and evaluate the home and need for services?
- Do you ever feel rushed by the case manager?
- Do you feel like you can discuss your needs with your case manager?
- Do you have the services you need?
- Are you satisfied with your services?
- Is there anything you would change?

### **C. PROVIDER QUALITY ASSURANCE**

#### **Prospective (New) Direct Service Providers**

The SAIL Waiver program has two open enrollment periods for any prospective vendor that expresses interest in becoming a DSP for the SAIL Waiver program. The enrollment periods will be from January 1st through the last day of February and June 1st through the last day of July.

The interested vendor for personal care and personal assistance services will need to contact the SAIL Waiver staff responsible for vendor enrollments. The prospective vendor will be sent a copy of the Waiver document Scope of Services for both personal care and personal assistant services. They will also receive an outline of the administrative and personnel requirements and responsibilities, and reimbursement rates.

The vendor should read through the Scope of Services, the requirements and the responsibilities to ensure an understanding of the program and their responsibilities.

Once the vendor has the requirements in place and has an understanding of the Scope of Service and is ready to proceed with the application process, they will contact the SAIL staff responsible for vendor enrollments.

Once the vendor has stated readiness to proceed, the SAIL staff will schedule an initial visit for review of the administrative and personnel requirements. Initial on-site visits are made to all new DSPs.

The perspective DSP must be found in compliance with all State and Federal HCBS waiver regulations before entering into a Memorandum of Agreement. The State of Alabama Independent Living (SAIL Waiver) Program, as the operating agency for the Alabama Medicaid Agency (AMA) SAIL Waiver, has the authority to enter into a Memorandum of Agreement with the DSP of personal care and personal assistant services.

#### **A. Prospective Provider Files to Audit:**

Employee files, audit all per Alabama Medicaid Agency

“Statewide background checks will be required for all service employees and for any employee who operates within the State of Alabama and has access to client records. Branch office employees including non-visiting employees employed by the DSP and who have access to client records are required to undergo background checks. Out-of-state corporate office employees will not be required to have a background check.”

#### **B. The Initial Audit Requirements**

##### 1. Administrative:

- Key Staff, i.e. administrator, supervisor (present during audit)
- Organizational Chart
- Infection control policy/procedures
- HIPAA policy
- Complaint and Grievance policy
- Policy and Procedure manual
- Proof or current Liability insurance
- In-service training plan (approved by SAIL)
- Emergency plan
- Annual operating budget
- An appropriate place to conduct business

If this office space is in a home then the following is required:

A room specified for the business must be separate from a personal dwelling area in a home. The room must be designated as the work space and can be closed off from the rest of the house.

Furniture, equipment, and supplies shall be distinctly related to a business office. Bedroom furniture, clothing, gym equipment, etc. Shall not be stored in this space.

Business and confidential files must be kept in a locked file cabinet.

Children, friends, family members shall not use or occupy the office area unless they are employed by the business.

A telephone line with a phone number different from the home residence is required. This number shall also have a voicemail or an answering service.

A sitting area must be included in the office space to meet with clients and business associates.

## 2. Personnel:

All employees must meet employee requirements.

All employees must meet worker training requirements.

Proof/copy of Statewide, County and Municipalities Background checks on all employees.

Proof/copy of National Sex Offender Registry checks.

Proof/copy of Alabama Certified Nurse Aide Registry checks.

SAIL will consult with AMA regarding prospective providers, to ensure they are in good standing, before the audit. A DSP that is on probation with another waiver program or under investigation by AMA will not be considered until the probation/investigation is resolved. Also the SAIL staff will review the AMA's website and Office of the Inspector General's website (<http://oig.hhs.gov/exclusions/index.asp>) to ensure the owner and any other professional staff identified have never been debarred.

If during the initial audit the vendor does not meet all the requirements, the audit will conclude and the DSP will be required to continue to work toward business readiness. The SAIL staff responsible for enrollments will provide technical support in meeting the requirements. Once the vendor believes they have all the requirements in place, a follow-up audit will be performed.

If during the audit, the DSP seems to have all the requirements in place, they move into the agreement phase. The SAIL staff responsible for enrollments will make a visit to review the application package contents and the Memorandum of Agreement requirements.

If after the 2<sup>nd</sup> audit the DSP is still out of compliance and/or has problems meeting the requirements, the enrollment process ends. The prospective DSP is notified in writing of the findings and the appropriate corrective action plan is provided. The Memorandum of Agreement will not be completed until the perspective DSP is in full compliance.

Once the DSP is in full compliance an application package will be completed. It will include the following:

Memorandum of Agreement 3 copies

Attachment A: Service and Provision and Rates

Attachment B: Areas Served for Personal Care and Personal Assistants

Attachment C: Personal Care Scope of Service

Attachment D: Personal Assistant Scope of Service

Attachment E: List of Vendor's Business Holidays

Attachment F: Vendor's Organizational Chart

Attachment G: Supervisory Nurse's Valid State License Documentation

Attachment H: Proof of Insurance

Liability

Worker's Compensation

Attachment I: Copy of Vendor's Business License

Attachment J: Annual Operating Budget

Attachment K: Six (6) months of Bank Statements

ADRS Vendor enrollment packet includes:

Non-Medical Vendor Application

Compliance with Drug Free Workplace

Non-Debarment Certification

Non-Discrimination Certification

IRS W-9

Immigration Status Form

The DSP will electronically enroll in the STARRS system prior to the application submission.

The Memorandums of Agreement can be for a six (6) month provisional which requires the vendor to fully demonstrate that they are able to perform in accordance within the regulations and guidelines, or the Memorandums of Agreement can be for three (3) years.

The vendor upon completion of the application package will return three signed copies of the MOA to the state office for processing. The SAIL staff will review the application to ensure that all the forms and documentation are present and completed properly. If any information is missing, the vendor will be notified by phone. The missing information must be submitted within seven (7) business days of the notification. If the vendor does not provide the information, the application will be returned to the vendor. No Memorandum of Agreement will be processed that does not contain all the required documents, forms and/or other information.

At this time, the SAIL staff will again review the AMA's website and Office of the Inspector General's website (<http://oig.hhs.gov/exclusions/index.asp>) to ensure the owner and any other professional staff identified have never been debarred.

Once the application package has been reviewed and is complete, the Memorandum of Agreement will be forwarded to the ADRS Legal Division for review. Once the legal review is completed, the MOA will be forwarded to the ADRS's Commissioner for signature.

The Commissioner will return the signed copies to the SAIL staff responsible for vendor enrollments.

The SAIL staff will forward the signed Memorandum of Agreements to the Alabama Medicaid Agency (AMA) Long Term Care (LTC) Division Director for review along with a request for a Certificate of Need (CON). Once the MOA has been signed by the Commissioner and the CON letter has been signed by the LTC Division Director, two original copies of the MOA will be returned to the SAIL staff responsible for enrollments.

The ADRS Accounting office will be notified and all necessary forms required by accounting will be sent to the Chief Financial Officer. The Accounting office will place the vendor on the list of active businesses.

The SAIL staff will notify the vendor that they are now on the active business list and is scheduled for the required training. The required training is offered in the month proceeding the open enrollment periods. If the vendor does not attend the required training, they are not allowed to provide services.

Once the training is completed the SAIL field staff are informed that a new vendor has been enrolled and is placed on the vendor choice form.

If the vendor is placed on the form with a provisional MOA, an audit will occur 45 days prior to the end of the provisional MOA. If they complete the audit successfully, they will receive a three (3) year MOA.

If the vendor has a three year MOA, an audit will be completed every year and will be performed at least 45 days prior to the end of each year of the MOA. At that time it will be determined as to whether or not the vendor meets the requirements and the MOA process begins again.

The SAIL staff will complete a monthly review of the AMA's website and Office of the Inspector General's website (<http://oig.hhs.gov/exclusions/index.asp>) to ensure the owner and any other professional staff identified have never been debarred, as long as they are a vendor. If at any time during the application process, the MOA, or during the provision of services the vendor has been debarred, SAIL will terminate the vendor immediately.

## **Established Provider Audit Process**

The SAIL audit personnel will schedule routine on-site audits of the DSP as required by the waiver document.

Each new DSP will have bi-annual audits for the first year. After that the DSP will receive annual audits. If on the annual audit a DSP is found to meet waiver regulations, with minimal or no findings, an audit is not required but is optional for the next fiscal year.

If the DSP is found to be out of compliance, a Plan of Correction is implemented with at least yearly audits.

SAIL staff has the option to schedule an audit as announced or unannounced. An announced visit requires the auditor to send prior notification to the DSP. The unannounced audit required no prior notification to the DSP.

### **A. The Announced Audit:**

The DSP will be called and a visit will be scheduled

The SAIL auditor will explain the process to the DSP including what is needed for the audit and the time frame (months) to be audited. (The minimum time frame to be audited will be four (4) months).

The DSP will be notified by mail, email and/or fax. A letter stating the date of the visit and other information regarding the audit, including a form on which the DSP will list all the SAIL waiver clients served during the audit period.

The DSP will have all the records of the clients served during the time frame ready for review. This includes time sheets, billings, missed visit reports, and supervisory visits.

### **B. The Unannounced Audit**

The unannounced audit required no prior notification to the DSP. The Auditors will explain the process to the DSP including what is needed for the audit and the time frame (months) to be audited at the time of arrival. (The minimum time frame to be audited will be four (4) months).

### **C. Procedure of Audit**

Entrance conference

Administrative Requirement Review  
Personnel Record Review  
In-service Training Review  
Client Record Review  
Billing Review  
Exit Conference

**D. Files to be audited:**

Employee files. The Administrator, RN supervisor, and RN/LPNs that perform supervisory visits will be audited. All employees providing personal care and personal assistant services will be audited.

Client files. All client files will be audited.

The SAIL reviewer will review all pertinent documents. Depending on the nature of the discrepancies found at the time of the audit and the seriousness of the violations, the reviewer will make recommendations for termination or corrections. The DSP will not have the opportunity to correct deficiencies found during an announced visit. Examples would be misplaced personnel forms, missing TB skin test in employee files, or missing supervisory visits.

During the exit conference, the SAIL reviewer will discuss findings with the DSP. The reviewer will also provide recommendations for corrections. A copy of the findings and recommendations will be left with the DSP at the time of the audit. The audit tool will not be provided to the DSP. On a scheduled audit the DSP must have the administrator, office manager and the supervisory nurse present during the exit conference. Absences of the required staff from the exit conference could result in termination of the Memorandum of Agreement.

During an unannounced audit, the DSP will have 24 hours or the end of the next business day, to provide the auditor any missing documentation discovered during the audit.

## **Plan of Correction**

When a Plan of Correction is required the DSP will have fifteen (15) days from the receipt of the letter to submit a Plan of Correction to the SAIL reviewer. (If the findings are minimal, the DSP can chose to provide the Plan of Correction while the SAIL reviewer is present.)

The Plan of Correction must address each area of non-compliance, the Plan for Correction each area and the identity of the DSP personnel responsible for ensuring the issues are corrected or monitored.

The SAIL staff will review the Plan of Correction and the written response will be sent to the DSP with the decision as to whether the Plan or Correction is approved/acceptable or denied/unacceptable.

If the plan meets SAIL Waiver requirements, a letter will be sent to the DSP stating that corrections have been approved. SAIL staff will schedule audit if required.

If the Plan of Correction is unacceptable and does not meet SAIL requirements the DSP will be contacted by mail and/or email with a formal notice. The concerns with the Plan of Correction will be addressed and the DSP will be offered an opportunity to resubmit a Plan of Correction within fifteen (15) days of the written notice their plan was denied/unacceptable.

Upon receipt of the second Plan of Correction, a determination will be made to determine if the Plan of Correction is acceptable/approved or unacceptable/denied. If the plan is acceptable, a letter will be sent to the DSP notifying them the plan is approved.

If the plan is unacceptable, a letter stating that is does not meet the requirements outlined in the SAIL waiver guidelines and the Alabama Medicaid Agency (AMA) Long Term Care Quality Assurance (LTC/QA) unit will be notified. SAIL staff will request that the AMA contact the DSP to schedule an on-site audit which includes outreach and/or education.

SAIL will provide the AMA/QA unit copies of the audit findings, plan of corrections and the letter stating the plan was unacceptable. SAIL will put their request in writing for Medicaid LTC/QA unit to conduct an on-site audit. Results of the AMA LTC/QA unit audit along with recommendations for continuation or termination of the contract with SAIL and DSP will be sent to the SAIL audit staff. The Medicaid LTC/QA and the LTC/Program Management Unit will be responsible for carrying out any further sanctions against the DSP which are deemed necessary by the AMA

If the DSP does not respond to SAIL's request to submit a Plan of Correction that is required during the allotted time period, SAIL will send a follow-up letter to the DSP stating the findings and recommendations of the audit. The DSP will be advised to submit a Plan of Correction with ten (10) days. A copy of this letter will be sent to the AMA /QA

and Program Management Unit. If the plan is not received in ten (10) days, the SAIL staff will notify AMA /LTC/QA and Program Management Unit.

A.M.A./LTC/QA and Program Management Unit will make the determination as to procedure requires to bring the DSP into compliance and will notify SAIL staff of the results. Based on the information received from AMA, SAIL will act according to AMA recommendations regarding the vendor. Recommendations may include suspension of payments to the DSP or termination of the DSP from the SAIL waiver program participation.

If during the audit, major deficiencies are found in all areas of the audit process, the DSP will be notified of the findings during the exit conference. SAIL staff will immediately notify AMA/QA and Program Management Unit of the deficient upon return to the SAIL office. If the deficient are significant SAIL staff may request to terminate the DSP from the SAIL waiver program. Once the decision is made, the DSP will be notified by formal letter that they must submit a Plan of Correction or that their participation in the SAIL waiver program has been terminated.

### **Follow-up Visits**

Follow-up visits will occur depending on the seriousness of the discrepancies noted during the SAIL audit. If major deficiencies in one area of the audit tool, a six (6) month follow-up visit will be necessary. If major deficiencies in two or more of the audit tool areas are found in a majority of the records reviewed, a three (3) month follow-up visit will be necessary.

Findings in all areas of the audit tool will constitute a major deficiency and a follow-up visit will be necessary.

During the follow-up visit, the SAIL reviewer will conduct the audit by reviewing the Plan of Correction and monitoring the DSP's current documentation ensuring the Plan of Correction is being implemented. As exit conference will be held with the DSP following the same procedures identified previously.

### **Probation**

If major deficiencies are found in three or more of the audit areas in a majority of the records audited, the DSP should be placed on probationary status. The SAIL reviewer will have verbally reviewed the findings at the time of the exit conference. The SAIL reviewer will discuss the DSP's right to appeal the decision or findings.

The areas of the audit tool include:

DSP Administrative requirements: Liability insurance, Policy and Procedures,  
Personnel requirements: TB tests, training, background checks  
Client records: client demographics, recording keeping information  
Billing: Bills, supervisory visits, missed visit, inaccurate billings

Once the audit is completed and probation is recommended, the SAIL auditor will notify the SAIL Director.

The DSP will be placed on a six (6) month probationary status. The probationary period will serve as a set time period in which the DSP is to make a concentrated effort to comply with SAIL waiver requirements. A formal letter will be sent to the DSP informing them of the six month probationary period. This letter will detail the findings of the audit and areas of non-compliance. The DSP will also be informed of its rights to appeal the decision or findings and request further training from SAIL. A copy of the audit information will be forwarded to AMA/LTC/QA and Program Management Unit.

A follow-up audit will be conducted after the six (6) month probationary period is completed. If the results of this follow-up audit indicate compliance with the SAIL waiver requirements, the probationary status will end.

If the DSP is not in compliance with the waiver requirements at the time of the follow-up audit, SAIL staff will notify the AMA /LTC/QA and Program Management Unit to recommend termination of the DSP's contract. Once AMA responds with their recommendations, SAIL will act accordingly.

## Health and Safety Violations:

- Missing and/or late TB tests
- Missing and/or late National Sex Offender Registry checks
- Missing and/or late Employee Background checks
- Missing and/or late Fraud/Abuse Registry checks
- RN/LP not meeting waiver requirements i.e. education, prior work experience, licensure

Upon audit review, if the SAIL reviewer determines that the health and safety is being compromised, the following steps may be taken depending on the seriousness of the deficiencies.

Immediate notification to the case managers to make other arrangements for the provision of services for the client including notification to the client's caregiver or responsible person and contract with another DSP to ensure health and safety.

Immediate notification to the SAIL Director providing information on steps taken to ensure health and safety of the waiver clients

Immediate Plan of Correction from the DSP covering the health and safety issue with a written Plan or Correction to follow within fifteen (15) working days. The Plan of Correction should set forth time lines reasonable to correct the identified problems and steps the DSP has taken to ensure the problem will not reoccur. If, a Plan of Correction is not implemented, case manager will be notified to move clients to another DSP, The SAIL Director will be notified.

SAIL reserves the right to place the DSP on immediate probation. SAIL reserves the right to review the DSP audit results to determine recommendations for suspension or termination of the contract due to health and safety issues identified. Any recommendation to suspend or terminate a contract with a DSP for violations will be discussed with AMA/LTC/QA and Program Management Unit prior to implementation.

## **Adverse Action**

### **A. Retraining**

Each DSP will be provided the opportunity for retraining on the Scope of Services at the conclusion of the exit conference after the audit.

### **B. Recoupment**

SAIL may recoup funds previously paid to a DSP for several reasons that may include, but not limited to, health & safety, non-compliance with the required initial visit, supervisory visits, billing for services not provided, or other problems to be determined.

# APPENDIX

## **STATE RECOVERY PROGRAM, WHAT IS THAT????**

What is that? The State Recovery Program was established under federal law. It requires the Alabama Medicaid Agency to recover the costs paid by the Agency from the estates of deceased Medicaid recipients.

Who is affected? A person of any age permanently residing in a nursing facility, intermediate care facility for the intellectually disabled, or other medical institutions; and a person 55 years of age or older who received medical assistance for any services covered under the Alabama Medicaid State Plan (this includes any individual receiving Home and Community based services).

When does Estate Recovery occur? Estate Recovery happens only after the death of a person receiving Medicaid benefits under the effected categories.

How does Estate Recovery work when a Medicaid recipient dies? The provider, attorney, personal representative, or case manager should contact the Alabama Medicaid Agency's Estate Recovery section to provide notification of a recipient's death within 30 days of the death. This notification can be by phone, fax, email, or mail.

What property is subject to estate recovery? All real and personal property and any other assets included within the individual's estate as defined by Alabama Probate Law. This definition includes, but is not limited to, homes, land, vehicles, cash and bank accounts.

What are the exemptions for estate recovery efforts? Estate Recovery will be delayed until after the death of the surviving spouse, if any, and if;

- a) There is a child under 21 years of age; or
- b) There is a blind or totally and permanently disabled child in the home.

In the case of liens placed on the home, recovery will be delayed until after the death of the surviving spouse, if any, and if:

- a) A sibling is lawfully living in the home and was lawfully residing continuously in the home for at least one year immediately prior to the claimant being admitted to the medical institution; or
- b) If there is a son or daughter of the Medicaid recipient who is and has been residing in the home for at least two years immediately before the date of the individual's admission to the institution, and has been residing there on a continuous basis since that time. The son or daughter would have to establish to the Alabama Medicaid Agency's satisfaction that they were providing care which permitted the individual to reside at home rather than in a medical institution.

Are there any situations when a TEFRA lien would not be placed on my home when I enter a nursing facility?

- a) If there is a spouse residing in the home;
- b) If there is a child under age 21 or blind or disabled residing in the home; or

c) If there is a sibling of the Medicaid recipient who has an equity interest in the home and is currently residing in the home and has been residing continuously in the home for at least one year immediately before the date of the individual's admission to the institution.

We never really "got married", but we lived together as husband and wife. Do the Estate Recovery regulations still apply to us? Yes; please contact an Elder Law attorney if you have any other questions or concerns.

What happens if someone has been paying taxes and upkeep expenses for maintaining the deceased's vacant home? An amount equal to the necessary and reasonable expenses for maintaining the vacant home will be deducted from the TEFRA lien amount. This would only apply to cases regarding Medicaid recipients that were required to sign a lien during the eligibility process.

Is it true that I have to turn my home over to the state when I move to the nursing facility or begin receiving home and community based services? No. You do not have to sign over the deed to the state; however, you could be required to sign a lien if you are in a nursing facility, intermediate care facility for the intellectually disabled, or other medical institutions. The lien will act as the state's claim should the property be sold prior to the Medicaid recipient's death. A lien is not required for recipients receiving home and community based waiver services.

What if both my name and my spouse's name are on the deed? Depending on the wording of the deed, property may be a recoverable asset after the Medicaid recipient's death (if no exemptions apply). If you have more specific questions about the particular wording, you will need to contact an attorney.

What if only my spouse's name is on the deed? The only recovery would be if your spouse received Medicaid services or if the property's ownership was transferred to you (the Medicaid recipient). Recovery would happen after the Medicaid recipient's death or when the exemptions no longer apply.

Can I give my home away before I enter the nursing facility or receive home and community based services? There are certain situations in which you could transfer the ownership of your property. You would need to contact an attorney to discuss those situations.

How do I transfer the deed to the property? It is very important you speak with an attorney that has knowledge of Medicaid policies before transferring any property.

How do I ask for a hardship waiver? If the heir feels he/she could be considered for an undue hardship, a request for the waiver application must be made within 30 days of receiving the Agency's notice against the estate, or upon the sale, transfer, or conveyance of the real property subject to a TEFRA lien.

All other attachments