PART II - CHAPTERS 600-1000

POLICIES
AND
PROCEDURES
FOR
COMMUNITY CARE SERVICES
(CCSP)

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

DIVISION OF MEDICAL ASSISTANCE

Published: July 1, 2015
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| **Section 600.1 of the CCSP General Services Manual** | J. The Georgia Medical Care Foundation (GMCF) reviews the member’s assessment documents and validates or denies the member’s need for a nursing home level of care. If the level of care is approved, GMCF issues a Level of Care Prior Authorization (LOC PA) for a length of stay of up to 365 days.  
K. The member's physician, familiar with the specific health and service needs of the member, provides the required medical information, approves the plan of care and attests to the member’s need for a nursing home level of care, and consults with the care coordinator as requested. |
<p>| <strong>Section 605.1 B of the CCSP General Services Manual</strong> | A CCSP member must meet the level of care criteria for intermediate nursing home placement. The Georgia Medical Care Foundation (GMCF) must validate the member’s level of care (LOC) and assign a length of stay (LOS) not to exceed a maximum of 365 days. The member’s physician signs the Form 5588 (CCSP Level of Care Placement Instrument) to attest to the member’s need for a nursing home LOC, after which the CCSP care coordinator RN signs the 5588 to certify the LOC. CCSP services may not begin under the LOS indicated on the Form 5588 until the RN signs the form to certify the LOC. |
| <strong>Section 605.1 D of the CCSP General Services Manual</strong> | If a member needs a change in service within 60 days from the beginning date of the LOS, the care coordinator will document and date the added services on the Comprehensive Care Plan and provide a copy to the member’s physician and the service provider(s). No face to face visit or physician letter is required in this situation unless the client is returning to the community from a nursing/rehabilitation facility. See Appendix G of the CCSP General Manual. |</p>
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| Section 605.1 E of the CCSP General Services Manual | If a member with a current LOS under an LOC experiences a change in condition or change in status that requires the addition of new services and/or a change in the level of services, and the change occurs more than 60 days after the beginning date of the LOS, a new LOC assessment (reassessment) is not required. However, approval of the new comprehensive care plan by the member’s physician is required. The CCSP nurse care coordinator must make a home visit to assess the member’s condition and service needs. Changes must be documented on the comprehensive care plan, and the comprehensive care plan must be submitted to the member’s physician by way of the Physician Change in Services Letter (Appendix EE) to request his/her approval of the new plan of care. Copies of the Appendix EE with the physician’s signature and the updated comprehensive care plan must be sent to the provider for the member’s file. The following are examples of changes or new services for which physician approval is required:  
  * The new service to be added is a skilled service.  
  * The member needs a change in their level of Adult Day Health (ADH) services.  
  * The change is service is from one category to another, such as from personal support services (PSS) to alternative living services (ALS).  
  * A change in service or new service is required for a member after their discharge from a facility that requires a LOC on a DMA-6, such as a nursing or rehabilitation facility.  
  * A member transfers from one planning and service area to another and requires new services. |
| Section 605.1 F of the CCSP General Services Manual | ADH therapies, HDS and SNS (skilled services) additions require physicians orders before specific medical procedures can be provided. Orders for therapy services must include specific procedure and modalities used frequency and duration of services. |
| Section 606.1 of the CCSP General Services Manual | R. Schedule and complete an annual level of care (LOC) reassessment within 60 days of the expiration of the current length of stay (LOS)  
S. Arrange and complete a face to face nursing visit with the member when the member experiences a change in condition  
T. Coordinate transfer to other services when the member needs changes or other services (discharge or transfer to a hospital, nursing home, or other community-based care).  
U. If the member requests, assist the member with request for a hearing to appeal an adverse action affecting the member’s level of services. |
<p>| Section 606.4 of the CCSP General Services Manual (Note after 606.4 C 1) | If the level of care is not consistent with the comprehensive care plan, an addendum must be noted on the service order, and a copy of the Physician Change in Services Letter (Appendix EE) must be attached. |</p>
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<tr>
<td>Section 606.13 of the CCSP General Services Manual</td>
<td>The reference to the provider’s private pay rate has been removed. A CCSP service provider’s private pay rate does not have to be related to Georgia Medicaid’s reimbursement rate for CCSP services.</td>
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</tbody>
</table>
| Section 606.16 of the CCSP General Services Manual | A licensed physician, nurse practitioner or physician assistant must approve the member services listed on the Form 5588 (CCSP Level of Care and Placement Instrument) except in the following situations:  
  - The member experiences a change in condition that requires a new service, additional services (such as additional personal support service hours) or a change in the level of Adult Day Health services and the change occurs more than 60 days after the beginning date of the member’s current length of stay (LOS) under a nursing home level of care (LOC). The physician’s approval for new services or a change in the level of ADH services must be communicated through the physician’s signature on the Physician Change in Services Letter (Appendix EE).  
  - The care coordinator adds other CCSP services within 60 days of the beginning date of the current LOS under a nursing home LOC. |
| Section 606.20 C of the CCSP General Services Manual | The second bullet of the section, “Once a member is placed in a nursing facility, the CCSP Level of Care is invalid,” has been removed. The length of stay (LOS) under an approved nursing home level of care (LOC) is now valid for the entire LOS, regardless of any nursing home stays the member may have during the LOS.  
  - If a nursing facility discharges a member who needs CCSP services reinstated, the nurse care coordinator must complete a face to face review of the member, within 48 hours of having received notice of the discharge, to assess the need for services not currently included on Form 5588 (CCSP Level of Care and Placement Instrument). If new services are indicated, the nurse care coordinator must document the new services on the member care plan and submit a request for approval to the member’s physician on the Physician Change in Services Letter (Appendix EE). |
<p>| Section 901 F of the CCSP General Services Manual (Exception following 901 F) | EXCEPTION: An individual who is receiving hospice services and is admitted to ALS (a personal care home) as a hospice client may not receive CCSP services. A CCSP client who is living in ALS at the time hospice services are ordered may continue living in ALS as a CCSP member. A member who begins hospice services after already in ALS, and they were not placed in ALS by the hospice agency, may receive concurrent hospice and CCSP services. |
| Appendix DD | The Critical Incident Report has been “renumbered” from Appendix EE to Appendix DD. |</p>
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<tr>
<td>Appendix EE</td>
<td>This appendix is to accommodate the addition of the new Physician Change in Services Letter, which will be used to request the physician’s approval for new services or a change in the level of ADH services during a current length of stay under a nursing home level of care.</td>
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### Policy Revisions included in the April 2015 Edition of the CCSP Policy Manuals

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<tr>
<td>Section 605.1 D of the CCSP General Services Manual</td>
<td>The manual was updated to make it clear that OUT OF HOME RESPITE is one of the services that can be added within 2 months of the assessment or reassessment by updating the care plan. The addition of IN-HOME RESPITE, aka extended personal support services, does require a new assessment.</td>
</tr>
<tr>
<td>Section 606.11 of the CCSP General Services Manual</td>
<td>NOTE: The Elderly and Disabled Waiver 1915 (c) does not include transportation in the rate for personal support or extended personal support services. NET is available to all Medicaid participants under the State Plan to provide transportation to medical appointments and for waiver services such as adult day health. A provider who allows an aide to make use of a member’s or aide’s car for transport needs to be sure the member’s or aide’s auto insurance assumes liability in case of an accident. Consider having the member or their family sign an agreement that discusses the assumption of liability in case of an accident. The provider should also carry adequate liability and worker’s comp insurance to cover any accidents. Any such transportation activities are at the risk of those who engage in them. Providers should consult their legal team to determine the extent of liability to which the agency may be exposed through such transportation activities, particularly if an aide assumes that this is part of their normal duties.</td>
</tr>
<tr>
<td>Appendix E of the CCSP General Services Manual</td>
<td>The Level of Care form, also known as Form 5588, was updated to reflect the new requirement not to exceed 365 days for a length of stay. See the instructions for Item 44 of the form.</td>
</tr>
<tr>
<td>Preface of the CCSP Adult Day Health Services Manual</td>
<td>A reference to Chapter 111-8 Healthcare Facility Regulation, Chapter 111-8-1 Rules and Regulations for Adult Day Centers has been added to the Preface of this manual, as Adult Day Health providers must now maintain a state license and must follow all the Adult Day Center licensing regulations in addition to the CCSP Adult Day Health Services Manual and the Medicaid Part I and Part II Manuals cited in the Preface.</td>
</tr>
<tr>
<td>Section 1101 of the CCSP Adult Day Health Services Manual</td>
<td>This section was updated to make it clear that Health-Related Services includes nursing, health monitoring and medication administration, and that Food Services includes nutrition management.</td>
</tr>
<tr>
<td>Section 1103.1 A of the CCSP Adult Day Health Services Manual</td>
<td>Item 18 was added to the physical environment requirements for an adult day health center to require an operational washer and dryer for standard precautions, including soiled/dirty items and infection control.</td>
</tr>
<tr>
<td>Section 1406 of the CCSP Personal Support Services Manual</td>
<td>The section on the role of the fiscal intermediary was updated to add the responsibility of ensuring that potential employees are at least eighteen years of age, certified in Cardiac Pulmonary Resuscitation (CPR) and basic first aid and are free of tuberculous (TB).</td>
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Policy Revisions included in the January 2015 Edition of the CCSP Policy Manuals

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<tr>
<td><strong>Section 601.2 of the CCSP General Services Manual</strong></td>
<td>Several updates were made to this section, including new licensing requirements for Adult Day Health and new pre-qualifying requirements for Alternative Living Services – Family Model and Emergency Response Service. New applicant should read this section carefully before beginning the application process.</td>
</tr>
<tr>
<td><strong>Section 601.3 of the CCSP General Services Manual</strong></td>
<td>Updates to this section include procedures for adding an additional services location for an existing service and conditions under which the $200 application fee is waived. Please read this section carefully before submitting any request to expand services or add an additional service location.</td>
</tr>
<tr>
<td><strong>Section 601.1 Q of the CCSP General Services Manual</strong></td>
<td>The minimum network meeting attendance requirement for CCSP providers can consist of participation via Webinar, when available, for one meeting, and attendance in person at another meeting.</td>
</tr>
<tr>
<td><strong>Section 601.5 A 1 of the CCSP General Services Manual</strong></td>
<td>The reference to the Part I Policies and Procedures Manual that concerns record retention has been updated to make reference to the correct section of the manual.</td>
</tr>
<tr>
<td><strong>Section 605.1 of the CCSP General Services Manual</strong></td>
<td>Beginning January 2015, A level of care (LOC) certification is approved for no more than a 365 day length of stay. If a CCSP member receives no waivered service within two months of the beginning date of the length of stay authorized under the Georgia Medical Care Foundation’s level of care prior authorization (PA) or the assessment date, whichever date is later, a new LOC certification is required. Section 605.1 has also been reordered to make it easier to follow and understand, so please review it carefully.</td>
</tr>
<tr>
<td><strong>Section 606.4 C 1 b of the CCSP General Services Manual</strong></td>
<td>The documents that must be included in the referral packet have changed. The assessment detail and triggers have been taken off the list, and the Care Plan has been expanded to include the CAPs, Service Order and Task Lists.</td>
</tr>
<tr>
<td><strong>Appendix G of the CCSP General Services Manual</strong></td>
<td>A revision to the instructions for completion of the Comprehensive Care Plan has been added, as follows: <strong>NOTE on instruction 23:</strong> The signature of the collaborating team member is only required when the assessment is performed by an LPN or the service addition is made by a staff member other than an RN. (Rev 1/2015)</td>
</tr>
<tr>
<td><strong>Appendix S of the CCSP General Services Manual</strong></td>
<td>All the new rates effective October 2014 for personal support services and alternative living services have now been updated, including the new rates for consumer directed personal support services.</td>
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<tr>
<td><strong>Section 601.1 O of the CCSP General Services Manual</strong></td>
<td><strong>NOTE:</strong> ALS and ADH providers will complete an incident report of any event/situation that has placed the client’s health, safety, and/or welfare in jeopardy or at risk. <strong>If an incident that occurs in an ADH involves a member who resides in an ALS, the provider must also notify the ALS. (Rev. 10/14)</strong> All other service providers will complete an incident report of such events/situations if any of their staff were present at the time of the incident or were a part of the incident. Interventions must be specific to the client’s cognitive, physical or mental impairment and target reduction of risk for client injury and reduce risk of recurrent incidents.</td>
</tr>
<tr>
<td><strong>Section 606.1 O of the CCSP General Services Manual</strong></td>
<td>The SAF is created from the Service Order and reflects the number of days in the month. SAFs are generated initially and when there is a change in services. A copy of the initial SAF and any revised SAFs will be forwarded to the provider(s). Rev 10/14</td>
</tr>
<tr>
<td><strong>Section 603 B of the CCSP General Services Manual</strong></td>
<td><strong>NOTE:</strong> The member must be informed in writing in advance of running any credit checks. Rev 10/14</td>
</tr>
<tr>
<td><strong>Section 606.17 of the CCSP General Services Manual, last NOTE at the end of this section</strong></td>
<td>The RN or LPN who makes the supervisory visit must sign and date the documentation of the visit. If the supervisory visit was made by an LPN, the supervising RN must review and co-sign the documentation of the LPN’s visit within 10 days unless otherwise stated in the provider manual for the particular service. (Rev. 12/10; 10/14).</td>
</tr>
<tr>
<td><strong>Section 1002.1 of the CCSP General Services Manual (textbox at the end of this section)</strong></td>
<td>“Relative” is defined as a person who is related by blood or legal adoption within the third degree of consanguinity or by marriage. Third degree of consanguinity means mother, father, grandmother, grandfather, sister, brother, daughter, son, grandchild, grandson, aunt, uncle, great aunt, great uncle, niece, nephew, grandniece, grandnephew, 1st cousins, 1st cousins once removed and 2nd cousins. Rev 10/14</td>
</tr>
<tr>
<td><strong>Sections 1203.5 E and 1253.7 E of the CCSP Alternative Living Services Manual</strong></td>
<td>The supervisory nurse (LPN or RN) must review, sign and date the completed medication administration record (MAR) for the previous month by the first supervisory visit of each month. If the LPN signs the MAR, the RN must review the MAR and sign off after the LPN by no later than the next supervisory visit. Rev. 7/2014, 10/2014</td>
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<tr>
<td>Section 601.2 B 1 and Appendix FF</td>
<td>The Letter of Intent is now the Notice of Intent to Become a CCSP Services Provider (Appendix FF).</td>
</tr>
<tr>
<td>Section 601.2 C 1 b and Appendix Y of the CCSP General Services Manual</td>
<td>The AAA Consult Form has been added back to the manual as part of the provider application process.</td>
</tr>
<tr>
<td>Appendices GG and HH of the CCSP General Services Manual</td>
<td>Appendix GG is revised to reflect the new Letter of Intent to Become and CCSP Service Provider, and Appendix HH is now the revised Application Checklist.</td>
</tr>
<tr>
<td>Section 1203.5 E and Section 1257.7 E of the CCSP ALS Manual</td>
<td>The RN reviews, signs and dates the completed medication administration record (MAR) for the previous month at the first supervisory visit of each month.</td>
</tr>
<tr>
<td>Section 1203.6 of the ALS Manual</td>
<td>Disaster Preparedness - The home adheres to the Rules and Regulations for Disaster Preparedness Plans, Chapter 111-8-16. (Chapter reference updated.)</td>
</tr>
<tr>
<td>Section 1253.7 G 3 of the CCSP ALS Manual</td>
<td>A copy of the current care plan, including any revisions, must also be maintained at the home at which the member resides.</td>
</tr>
<tr>
<td>Section 1501 of the CCSP Out of Home Respite Manual</td>
<td><strong>1501. Out-of-Home Respite Visits</strong></td>
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<th>Out-of-Home Overnight Respite</th>
<th>Out-of-Home Hourly Respite</th>
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<td>This Respite Care requires an out-of-home stay of <strong>twelve (12) hours or more (overnight)</strong>. A visit begins at the time the client enters an out-of-home facility for Respite Care and ends 24 hours later. As for ALS Services, bill for the date of admission but not the date of discharge. Rev 7/2014</td>
<td>Out-of-Home Respite is provided for a stay of from three hours to twelve hours. <strong>NOTE:</strong> Overnight respite and hourly respite can’t be billed for the same date. Rev 7/2014</td>
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<tr>
<td>Section 601.1 V and X of the CCSP General Services Manual</td>
<td>These sections were updated to refer the reader to their new requirements in the updated new provider enrollment process in 601.2.</td>
</tr>
<tr>
<td>Section 601.2 of the CCSP General Services Manual</td>
<td>This section has been completely revised to include the new procedures for enrolling new CCSP service providers and for service expansions for existing providers. Please read the entire section carefully.</td>
</tr>
<tr>
<td>Section 1007 of the CCSP General Services Manual</td>
<td>The ordering, prescribing and referring information has been updated. Georgia Medicaid will begin editing CCSP claims for an NPI number on file if an ordering, prescribing or referring provider is entered in the header or detail section of a claim.</td>
</tr>
<tr>
<td>Section 606.1 J of the CCSP General Services Manual</td>
<td>Determine if services are appropriate and effective, monitor changes in member’s health and review the comprehensive care plan at least every 90 days.</td>
</tr>
<tr>
<td>Section 606.1 Q of the CCSP General Services Manual</td>
<td>Providers enrolled in the CCSP are required to attend at least two of four quarterly AAA Network Meetings during the state fiscal year (July 1 – June 30) in the Planning and Service Areas (PSA) in which services are being rendered.</td>
</tr>
<tr>
<td>Appendix A of the CCSP General Services Manual, Requested Counties Form</td>
<td>The AAA consult form has been removed as obsolete and replaced with the Requested Counties Form that will be used when providers make service area expansion requests.</td>
</tr>
<tr>
<td>Appendix B of the CCSP General Services Manual, Service Expansion Application</td>
<td>This appendix has been revised due to the changes in new provider enrollment included in this manual update.</td>
</tr>
<tr>
<td>Appendix I of the CCSP General Services Manual, Community Care Notification, Form 6500</td>
<td>The CCNF has been revised to add a space for the e-mail address of the sender and recipient of the form.</td>
</tr>
<tr>
<td>Appendix AA of the CCSP General Services Manual, Georgia Families and Georgia Families 360</td>
<td>This appendix has been updated to reflect changes to the CMOs, including the addition of Georgia Families 360 in March 2014.</td>
</tr>
<tr>
<td>Appendix FF of the CCSP General Services Manual, Letter of Intent.</td>
<td>This appendix has been developed due to the changes in new provider enrollment included in this manual update.</td>
</tr>
<tr>
<td>Appendix GG of the CCSP General Services Manual, Pre-Qualification and Application Checklists</td>
<td>This appendix has been developed due to the changes in new provider enrollment included in this manual update.</td>
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<tr>
<td>Section 1006 L of the CCSP General Services Manual</td>
<td>The paper version of the CMS-1500 claim form has been revised. Please use the new version if submitting paper claims.</td>
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| Note following Section 1253.2 A of the CCSP ALS Family Model Manual | IMPORTANT NOTES on Registrations:  
If a family model personal care home relocates, the provider agency must submit new documentation to register the home at its new location prior to the relocation. The only exception to this policy is emergency relocation due to fire or natural disaster.  
Rev. 4/2014 |
| Section 1702 of the CCSP Home Delivered Meals Manual | The requirement that the member live alone or lack a support system has been removed. Members who receive services from a personal support aide may also receive home delivered meals. |
Policy Revisions included in the January 2014 Edition of the CCSP Policy Manuals

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<tr>
<td>Section 601.1 B of the CCSP General Services Manual</td>
<td><strong>Authorization Document</strong>: The provider agency, if incorporated, must submit to the CCSP and DCH a copy of its Good Standing - Certificate of Existence from the Office of the Secretary of State. <strong>The provider agency must also submit its current business license and/or other proof of legal authorization to conduct business in the State of Georgia. Rev. 7/1/13, 1/1/14</strong></td>
</tr>
<tr>
<td>Section 601.1 C of the CCSP General Services Manual</td>
<td>Licensure - If state or local law requires licensure of the agency, organization, facility or staff for the service the agency wishes to provide, the provider agency must submit proof of licensure to the Division of Aging Services, upon application and by request thereafter. The provider agency must post current licensure and permits (if applicable) in a conspicuous location open to public view. Licensure requirements for each service are included in each specific service provider manual. Rev. 1/1/14</td>
</tr>
<tr>
<td>Note after Section 606.1.C of the CCSP General Services Manual</td>
<td><strong>NOTE:</strong> In accordance with Section 105 of Part I Policies and Procedures For Medicaid/Peachcare for Kids, providers must be fully licensed without restriction. Provisional licenses are not acceptable. Rev. 1/1/14</td>
</tr>
<tr>
<td>Section 601.1 D of the CCSP General Services Manual</td>
<td>Compliance - Neither the provider agency nor its owner(s) or management may be currently under suspension from accepting CCSP referrals or delivering services in any Medicaid program. In addition, the provider agency must have had no deficiencies within the past three years from any licensing, funding or regulatory entity associated with enrollment in any Medicaid, Private Home Care, or Title III-funded services or with the provision of any related business, unless all such deficiencies have been corrected to the satisfaction of the imposing entity and the Division of Aging Services. Rev. 1/1/14</td>
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<tr>
<td>Section 601.1 H of the CCSP General Services Manual</td>
<td>Organizational Structure - The provider must diagram a readable organizational structure, administrative control, and lines of authority for the delegation of responsibility and supervision from the administrative level to the member care level, to include names and position titles. Rev. 1/1/14</td>
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<tr>
<td>Section 606.1.I, item 23, of the CCSP General Services Manual</td>
<td>Critical Incident Reporting policies and procedures are now required as part of the application package.</td>
</tr>
<tr>
<td>Section 601.1 V of the CCSP General Services Manual</td>
<td><strong>Enrollment Training - Pre-Enrollment Training</strong> – All applicants must attend pre-enrollment training. Providers currently enrolled in CCSP will be required to attend training at the discretion of the Division. <strong>New Provider Training</strong> - Attendance at new provider training is by official invitation only at the discretion of the Division. Rev. 1/1/14</td>
</tr>
<tr>
<td>Section 601.1 X of the CCSP General Services Manual</td>
<td><strong>Business Experience</strong> – All applicants must have been in the business for which application is being made for a minimum of twelve (12) consecutive months prior to making application for enrollment in the CCSP. This means actively serving clients at the time of registration and throughout the application process. CCSP will not recommend approval for a business to be a Medicaid provider in CCSP unless they are currently serving clients and have been serving clients for the past 12 months. Rev. 4/2011, 1/1/14</td>
</tr>
<tr>
<td>Section 601.1 Y of the CCSP General Services Manual</td>
<td><strong>Insurance Coverage</strong>- The applicant must submit proof that the provider agency has at least $1,000,000 in general liability insurance coverage. Private home care providers must submit proof of their agency’s worker’s compensation insurance coverage. Rev. 1/1/14</td>
</tr>
<tr>
<td>Section 601.2 B of the CCSP General Services Manual</td>
<td>Prospective CCSP providers receive pre-enrollment information and registration by:</td>
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<td>• Downloading the packet from <a href="http://aging.DHS.georgia.us">http://aging.DHS.georgia.us</a></td>
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<td>• Clicking on the “Publications” tab</td>
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<td>• Scrolling down to “Pre-Enrollment Provider Technical Assistance and Registration Form”</td>
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<td>• Faxing a request to 404-657-5251</td>
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<td>• Sending a written request to: Georgia Department of Human Services Division of Aging Services Community Care Services Program Two Peachtree Street, NW 33rd Floor Atlanta, GA 30303-3142 Rev. 1/1/14</td>
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July 1, 2015    Community Care Services
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| Section 601.2 D of the CCSP General Services Manual                           | The DCH Provider Application and CCSP Provider Enrollment Application must be submitted to the CCSP within 60 days of attending Pre-Enrollment CCSP Technical Assistance Training. The CCSP Provider Application must be typed or computer generated. Applications must be sent via postal mail. Faxed applications will not be accepted.  
|                                                                               | Rev. 1/1/14                                                                                                                                                                                                                                                             |
| Section 601.2 D of the CCSP General Services Manual                           | The Division of Aging Services will conduct site visits, if applicable. If the Division's site visit results in an unsatisfactory review, the Division will recommend denial of the enrollment application to the GA Department of Community Health.  
|                                                                               | Rev. 1/1/14                                                                                                                                                                                                                                                             |
| Section 601.2 H of the CCSP General Services Manual                           | When the entire application is completed to the satisfaction of the Division of Aging, the applicant will receive notification of the next scheduled New Provider Training.  
|                                                                               | Rev. 1/1/14                                                                                                                                                                                                                                                             |
| Sections 601.3 B and 601.4 D of the CCSP General Services Manual              | Address update for DAS/CCSP:                                                                                                                                                                                                                                             |
|                                                                               | Georgia Department of Human Services  
|                                                                               | Division of Aging Services  
|                                                                               | Community Care Services Program  
|                                                                               | Two Peachtree Street, NW  
|                                                                               | 33rd Floor  
|                                                                               | Atlanta, GA 30303-3142  
|                                                                               | Rev 1/1/14                                                                                                                                                                                                                                                             |
| Section 601.3 E of the CCSP General Services Manual                           | Capacity Increase - ALS Group ONLY - An ALS facility wishing to increase the bed capacity (up to 24 beds) of a currently enrolled personal care home must submit a completed Request for Approval to Increase Bed Capacity application to the Division of Aging Services. (See Appendix B of the ALS Manual for the application). An ALS facility is prohibited from increasing its census without DAS approval of the Request for Approval to Increase Bed Capacity application.  
|                                                                               | Rev. 1/1/14                                                                                                                                                                                                                                                             |
### Policy Revisions included in the October 2013 Edition of the CCSP Policy Manuals

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<tr>
<td><strong>CCSP General Services Manual, Section 601.1 Q</strong></td>
<td>Providers who serve more than one PSA region must meet their network meeting attendance requirement by attending meetings in different regions in different calendar quarters.</td>
</tr>
<tr>
<td><strong>CCSP General Services Manual, Section 606.4 C 14</strong></td>
<td>The member’s clinical record must include copies of the comprehensive care plan, updated every 90 calendar days.</td>
</tr>
<tr>
<td><strong>CCSP General Services Manual, Appendix E</strong></td>
<td>Use this version of the Level of Care form to replace earlier versions. The newly revised form will allow entry of diagnosis codes in both ICD-9 and ICD-10 formats in preparation for the switch to ICD-10 in 2014. Care coordination agencies are encouraged to begin entering diagnosis codes in both formats at all initial assessments and reassessments beginning immediately.</td>
</tr>
</tbody>
</table>
| **CCSP General Services Manual, Section 606.9 B** | Unlicensed proxy caregivers are allowed to perform certain health maintenance activities as long as they have the member’s full written informed consent and are trained and certified as specified in Chapter 111-8-100 of the Rules of the Georgia Department of Community Health, Healthcare Facility Regulation Division, entitled “Rules and Regulations for Proxy Caregivers used in Licensed Healthcare Facilities.”  

If a licensed nursing staff member or a proxy caregiver administers medications, member records must include, in addition to information specified in 606.9A of the CCSP General Manual, the following documentation:

1. **Physician's authorization for the administration of any medication.** The physician may renew this authorization on the Level of Care and Placement Instrument at the time of the member’s level of care re-determination or through written physician orders at any other time.

2. **When obtaining a physician's verbal authorization, documentation of the consultation, and written follow up within 30 days to confirm the authorization.**
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<td>(3) The name, dosage, route, and frequency of any medications administered by the licensed nursing staff member or proxy caregiver. The person administering the medication must sign and date all notations.</td>
<td>Elderly and Disabled Waiver members living in ALS facilities may receive services at an Adult Day Health Services facility for up to 2 full days per week.</td>
</tr>
<tr>
<td>CCSP Adult Day Health Services Manual, Section 1101.1 And CCSP Alternative Living Services Manual, Sections 1203.1 C 3 and 1253.1 C 3.</td>
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<tr>
<td>CCSP General Services Manual, Section 601.1.B</td>
<td>Authorization Document- The provider agency, if incorporated, <strong>must submit to the CCSP and DCH</strong> a copy of its Certificate of Existence – Good Standing Certificate from the Office of the Secretary of State. If the provider agency is not incorporated, it must have available its current business license or other proof of legal authorization to conduct business in the state of Georgia.</td>
</tr>
<tr>
<td>CCSP General Services Manual, Section 601.1.Q</td>
<td>Providers enrolled in the CCSP are required to attend at least two of four quarterly AAA Network Meetings during the state fiscal year <strong>in the Planning and Service Areas (PSA) in which services are being rendered.</strong> (Refer to attachment “A “for the counties served by the 12 PSA’s).</td>
</tr>
<tr>
<td>CCSP General Services Manual, Appendix B, Item 18, last bullet point</td>
<td>Submit a current copy of proof of your business’ liability insurance coverage in the amount of one million dollars. <strong>If you are applying to provide personal support services under CCSP as a private home care provider, include proof that worker’s compensation coverage is part of your insurance package.</strong></td>
</tr>
<tr>
<td>CCSP General Services Manual, Section 1007 (new section)</td>
<td>CMS expanded the claim editing requirements in Section 1833(q) of the Social Security Act and the providers’ definitions in sections 1861-r and 1842(b)(18)C. The Affordable Care Act (ACA) requires physicians or other eligible providers to be enrolled in the GA Medicaid Program to order, prescribe and refer items or services for Medicaid beneficiaries. Physicians or other eligible providers who are already enrolled in Medicaid as billing providers are not required to enroll separately as Ordering, Prescribing, or Referring (OPR) providers. Enrollment of these providers will begin on April 1, 2013. Beginning July 1, 2013, if the National Provider Identifier (NPI) of the ordering, prescribing, or referring (OPR) provider noted on the GA Medicaid claim is associated with a provider who is not enrolled in the Georgia Medicaid program, the claim <strong>will not be paid</strong>. Furthermore, the NPI of the provider ordering, prescribing or referring the member for the service rendered must be</td>
</tr>
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included on the claim submitted by the rendering provider. Providers who do not have NPIs and who are not authorized to enroll as Medicaid or CHIP providers (i.e. medical residents at hospitals) must apply the NPI of the supervising physician to the claim.
Policy Revisions included in the April 2013 Edition of the CCSP Policy Manuals

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<tr>
<td>Appendix E of the CCSP General Services Manual</td>
<td>The Level of Care form has been updated to facilitate routing to the physician and to update policy on who can sign the form.</td>
</tr>
<tr>
<td>Appendix EE of the CCSP General Services Manual</td>
<td>The Critical Incident Report Form has been updated.</td>
</tr>
<tr>
<td>Appendix V of the CCSP General Services Manual</td>
<td>Contact information for the AAAs and Care Coordination Agencies has been updated.</td>
</tr>
<tr>
<td>Section 1704.1.1 of the CCSP Home Delivered Meals Manual</td>
<td>A member is limited to a maximum of 14 meals per week, or 62 per month, plus emergency meals twice per year. (See below.)</td>
</tr>
<tr>
<td>Section 1704.3.E of the CCSP Home Delivered Meals Manual</td>
<td>Up to 6 shelf stable meals can be provided to a member no more than twice yearly to be held by the member for periods when conditions won’t permit meal delivery, such as emergency conditions caused by extreme weather, power outages, etc. The provider must communicate with care coordination to have these meals authorized in the care and service plans and service authorization. Provision of emergency meals must be clearly documented in the member’s record, including annotation on the delivery log.</td>
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<tr>
<td>Section 605.2 C of the CCSP General Services Manual</td>
<td>Evaluating a Member who is Transitioning to the Community under the Money Follow the Person (MFP) Program - When a provider receives a referral to provide services for a member who is preparing to be discharged from a nursing home to the community under the MFP program, the provider should conduct the face-to-face evaluation in the nursing home prior to discharge, as soon as possible after the referral is received. This is done so that services can begin on the first day the member returns home, as authorized by the CCSP care coordinator. A re-evaluation of the member’s needs can be conducted when services have started after the member is settled in the community, following the guidelines in Section 605.3 of this manual.</td>
</tr>
<tr>
<td>Section 606.7 A. 8 and B. 2 of the CCSP General Services Manual</td>
<td>If discharge occurs because the member enters another home and community based waiver, such as SOURCE, ICWP or NOW/COMP, send notice of discharge based on the discharge date negotiated with the new waiver case manager by the CCSP care coordinator, waiving the 30 day advance notice requirement.</td>
</tr>
<tr>
<td>Sections 1002 and 1003 of the CCSP General Services Manual</td>
<td>The section on relative caregivers has been revised as Section 1002. All relative caregivers must be approved in advance by the CCSP Program Specialist in the Medicaid Division of the Department of Community Health before they begin caring for a CCSP or SOURCE member. Reimbursement for relative caregivers, including the payment of overtime, is discussed in Section 1003. Please review these sections carefully.</td>
</tr>
<tr>
<td>Sections 1600.1, 1602.2, 1602.4 and 1602.6 of the CCSP Emergency Response Systems Manual</td>
<td>These sections have been revised to allow ERS providers to offer wireless ERS devices that use cellular technology. This is allowed for members who don’t maintain a land line telephone and are willing to sign a form saying they are accepting this type device as an alternative. All charging equipment and backup batteries must be provided as part of the wireless unit. Monthly testing is required as with any other ERS unit, and silent testing is not allowed.</td>
</tr>
<tr>
<td>Section 1405 of the CCSP Personal Support Services Manual</td>
<td>CCSP members in hospice and consumer direction can only have <em>extended</em> personal support services (in-home respite) authorized in their care plan.</td>
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<tr>
<td>Appendix I of the CCSP General Services Manual</td>
<td>The CCNF has been replaced with a new edition of the form. Please begin using this form effective immediately.</td>
</tr>
<tr>
<td>Appendix AA of the CCSP General Services Manual</td>
<td>The information on Georgia Families, which is the managed care part of Medicaid that involves the care management organizations (CMOs), has been updated. All the exempt classes of Medicaid eligibility, or aid categories, are listed in this appendix.</td>
</tr>
<tr>
<td>Appendix A of the CCSP Adult Day Health Manual</td>
<td>“Member Name” has been added to page 2 of the form before the Progress Notes. Enter the member’s name here to tie the progress notes to the specified member. This will help prevent problems when you have an audit of your program.</td>
</tr>
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<tr>
<td>Section 601.1 N of the CCSP General Services Manual</td>
<td>This revision is to confirm that ERS providers do not have to maintain an office in Georgia in order to be Georgia Medicaid service providers.</td>
</tr>
<tr>
<td>Appendix T of the CCSP General Services Manual</td>
<td>This Appendix has been updated with information on the new NET brokers.</td>
</tr>
<tr>
<td>Section 1203.4 B and 1253.6 B of the CCSP Alternative Living Services Manual</td>
<td>The supervisory visit requirement has been updated to make it the same for group and family model ALS homes. New guidelines on additional requested visits have been added. Please read these sections carefully.</td>
</tr>
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Policy Revisions included in the April 2012 Edition of the CCSP Policy Manuals

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<tr>
<td>Section 606.16 C of the CCSP General Manual</td>
<td>Documentation requirements for supervisory visit notes have been changed to require the signature of the nurse and the date of the visit, plus the date of the previous supervisory visit.</td>
</tr>
<tr>
<td>Section 1203.4 B of the CCSP Alternative Living Services Manual</td>
<td>Supervisory visits must be conducted at least every other week, with no more than 16 days between each visit. At least every other visit must be conducted by the RN.</td>
</tr>
<tr>
<td>Section 1703.1 A of the CCSP Home Delivered Meals Manual</td>
<td>Item 2 has been inserted to require the HDM provider to provide each member with safe storage, handling and preparation instructions for alternative meals.</td>
</tr>
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<tr>
<td>Note following Section 605.2 of the CCSP General Manual</td>
<td>CCNF and provider referral packets may be submitted electronically using encryption or a secure Web site.</td>
</tr>
<tr>
<td>Section 1701 of the CCSP Home Delivered Meals Manual</td>
<td>HDM providers must be current non-Medicaid Title III / Social Services Block Grant (SSBG) Nutrition Contractors OR licensed and accredited hospitals or nursing facilities</td>
</tr>
<tr>
<td>Note following Section 1704.5 of the CCSP Home Delivered Meals Manual</td>
<td>Providers will be reimbursed for meals delivered on (or intended for in the case of weekly delivery) the date of the member’s admission to or discharge from the hospital. Date span billing across any nights in the hospital will result in denial or recoupment of the entire span.</td>
</tr>
<tr>
<td>Section 1706 of the CCSP Home Delivered Meals Manual</td>
<td>Frozen or shelf stable meals that are delivered weekly are to be billed for the date they are expected to be consumed. (EXAMPLE: Meals that are delivered for the 7 day week on Monday 10/1/12 must be billed for 10/1/12 through 10/7/12.)</td>
</tr>
<tr>
<td>Sections 1300 and 1301 of the CCSP Home Delivered Services Manual</td>
<td>The sections have been rewritten to clarify the definition of home delivered services, and that home health agencies must have a CCSP home delivered services provider number in order to render these services to a CCSP member after the 50 state plan visits are exhausted.</td>
</tr>
<tr>
<td>Section 1305 of the CCSP Home Delivered Services Providers</td>
<td>The procedure code for nursing visits has been corrected to T1030 TD.</td>
</tr>
<tr>
<td>Section 1403.1.B of the CCSP Personal Support Services Manual</td>
<td>Item 7 is added to emphasize the policy that no aide is to be employed who has been convicted of any of the felonies listed in Section 1406 of the PSS Manual.</td>
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## PART II - POLICIES AND PROCEDURES FOR COMMUNITY CARE SERVICES

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609.2 Program Evaluation and Customer Satisfaction
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702 VERIFICATION OF MEDICAID ELIGIBILITY

CHAPTER 800 PAYMENT AUTHORIZATION

801 PRIOR APPROVAL

802 PREPAYMENT REVIEW

803 DMA-80s FOR PMAO CLIENTS

804 COST SHARE AND THE CCSP COST LIMIT

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PREFACE

Policies and procedures in this manual apply to all Community Care Services Program providers. See Specific Program Requirements Chapters (under separate cover) for additional policies and procedures specific to each service type:

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All Community Care providers must adhere to Part I - Policies and Procedures for Medicaid/Peachcare for Kids
PART II CHAPTER 600

CCSP SERVICE OVERVIEW

600. Introduction to the Community Care Services Program

The Community Care Services Program (CCSP) operates under a Home and Community-Based Waiver (1915c) granted by the Centers for Medicare and Medicaid Services (CMS). This Waiver permits the Division of Medical Assistance to use Title XIX funds to purchase services for CCSP members who meet program requirements.

The Community Care Services Program assists individuals who are older and/or functionally impaired to continue living in their own homes and communities as an alternative to nursing home placement. Individuals served by the program are required to meet the same level of care for admission to a nursing facility and be Medicaid eligible or potentially Medicaid eligible.

The Community Care Services Program is a consumer-oriented program, with the following goals:

- To provide quality services, consistent with the needs of the individual member, which are effective in improving/maintaining the member's independence and safety in the community as long as possible.

- To provide cost effective services.

- To involve the member or member’s representative in the provision and decision-making process regarding member care.

- To demonstrate compassion for those served by treating members with dignity and respect while providing quality services.

Provision of quality services and supervision of member care are vital to preventing premature institutional placement. Service providers are expected to be qualified and to provide services in compliance with the policies, procedures, and goals of the CCSP and of any other applicable regulatory agency. (See Section 601.1)

Providers’ performance standards must exceed basic licensing requirements; specific areas of accountability include:

- Reliability of service

- Competency and compatibility of staffing

- Responsiveness to members' concerns

- Communicate and coordinate services with care coordination staff
The Community Care Services Program operates on a defined fiscal year budget and may not exceed budget allocations. When budget allocations are at maximum use and the Program is "full", eligible members needing services are placed on a waiting list to be admitted for services only as member discharges occur and as funding permits.

The Community Care Services Program Policies and Procedures Manuals define standard policies and procedures for services provided in the CCSP. All enrolled providers must adhere to the requirements as outlined in these manuals.

600.1 **Structure and Administration of the Program**

Services under the CCSP are provided with the cooperation of the following state and local public agencies and private businesses:

A. The Division of Medical Assistance (DMA) of the Department of Community Health is responsible for provider enrollment and reimbursement to providers for services provided to those members who have applied and been approved for the Program. DMA conducts utilization reviews of providers to assure that only authorized and appropriate CCSP services are delivered.

B. The Division of Aging Services (DAS) of the Georgia Department of Human Services (DHS) is responsible for the overall coordination, administration, and quality assurance of the program. DAS reviews and recommends approval of provider enrollment applications, conducts site visits and provider training. DAS provides Adult Protective Services (APS) for the prevention of abuse, neglect and exploitation of individuals.

C. The Georgia Department of Behavioral Health / Developmental Disabilities, and Addictive Diseases, provides psychological and psychiatric evaluations and therapeutic services through regional boards.

D. The Division of Family and Children Services (DFCS) of the Georgia Department of Human Services determines Medicaid eligibility and member cost share (if any) for potentially Medicaid eligible members entering the CCSP.

E. The Office of Information Technology (IT) of the Georgia Department of Human Services provides information technology to the Division of Aging Services and Area Agencies on Aging regarding service authorization.

F. The Healthcare Facility Regulation Division (HFRD) of the Georgia Department of Community Health licenses and monitors personal care homes, private home care providers and home health agencies.
G. Area Agencies on Aging (AAA)/Lead Agency (12 statewide) are designated in each Planning and Service Area by the Division of Aging Services as the local administrator and points of contact for members or members’ representatives, service providers, and potential service providers. The Lead Agency assures program accessibility by serving as the focal point responsible for local administration, coordination and implementation of the CCSP, including telephone screening of all potential CCSP members.

H. Hewlett Packard (HP) (GHP) is under contract with DMA to reimburse Medicaid provider(s) and operate the Provider Enrollment Unit. GHP distributes information about enrollment, trains Medicaid providers in the billing process, and reimburses them for authorized services. GHP also operates the Billing Inquiry Unit to assist Medicaid providers with questions related to billing.

I. The Care Coordinator (CC) facilitates the process of assessing, planning, authorizing, arranging, coordinating, and evaluating service delivery to the CCSP member. The care coordinator provides the member and member’s representative with a single access of resource information. The Area Agencies on Aging either provide these services directly or contract with other entities to provide them.

J. The Georgia Medical Care Foundation (GMCF) reviews the member’s assessment documents and validates or denies the member’s need for a nursing home level of care. If the level of care is approved, GMCF issues a Level of Care Prior Authorization (LOC PA) for a length of stay of up to 365 days. (Rev 7/2015)

K. The member’s physician, familiar with the specific health and service needs of the member, provides the required medical information, approves the plan of care and attests to the member’s need for a nursing home level of care, and consults with the care coordinator as requested. (Rev. 7/2015)

L. Service Providers enrolled in CCSP deliver services as ordered on the care plan authorized by the care coordinator. By sharing information with the care coordinator, providers serve as a vital component of the member's care team.

600.2 Services of the Program

The Community Care Services Program offers the following services as an alternative to institutional care. Qualified providers may seek enrollment in one or more of the services.
M. **Adult Day Health** (ADH) provides nursing services, medical supervision, health, therapeutic, and social services activities in a congregate community-based day program.

N. **Alternative Living Service** (ALS) provides twenty-four-hour supervision, personal care, nursing supervision, and health-related support services in licensed personal care homes.

O. **Emergency Response System** (ERS) provides two-way verbal and electronic communication with a central monitoring station seven days a week, 24 hours a day to geographically and socially isolated members.

P. **Home Delivered Meals** (HDM) provide and deliver prepared meals to the CCSP member's home. Each meal meets at least 1/3 of the recommended daily nutritional requirement.

Q. **Home Delivered Services** (HDS) provide home health services rendered on an intermittent basis by certified, licensed home health agencies to members in their homes.

R. **Personal Support Services** (PSS) provide personal care tasks such as assistance with eating, bathing, dressing, personal hygiene, preparation of meals, light housekeeping tasks, and other activities of daily living. Extended Personal Support Services refer to those tasks designed for members who need assistance with activities of daily living, as well as relieve those person(s) normally providing care and/or oversight.

S. **Respite Care** (RC) provides for temporary relief of the individual(s) normally providing care. Respite Care is provided in an approved facility such as a personal care home or adult day health center. Respite care may include overnight care.

T. **Skilled Nursing Services** (SNS) by Private Home Care Providers provide skilled nursing intervention/monitoring when a home health agency is unable to provide service to the member.

600.3 **Authority**

In the Community Care and Services for the Elderly Act, (O.C.G.A. 49-6, Article 5). The Georgia General Assembly stated its intent as follows:

- To assist functionally impaired elderly in living dignified and reasonably independent lives in their own homes or with their families
- To establish a continuum of care for such elderly in the least restrictive environment suitable to their needs
To maximize the use of existing community social and health services to prevent unnecessary placement of individuals in long-term care facilities.

To develop innovative approaches to program management, staff training and service delivery that impact cost avoidance, cost effectiveness and program efficiency.

It is further the intent of the General Assembly that the Georgia Department of Human Services shall serve as the agency responsible for planning and implementing the provision of community-based services to the elderly reimbursable under the "Georgia Medical Assistance Act of 1977."

The Georgia Department of Human Services established a Community Care unit within the Division of Aging Services. The Community Care unit plans and oversees implementation of a system of coordinated community care and support services for the elderly. The Community Care unit develops uniform assessment criteria that are used to determine an individual’s functional impairment and evaluates on a periodic basis the individual's need for community support services or institutionalized long-term care.

601. **Conditions of Participation**

In addition to the conditions for provider participation in the Medicaid Program which are outlined in Part I - Policies and Procedures For Medicaid/Peachcare For Kids, Community Care Services Program (CCSP) providers must meet all the following conditions at the time of initial enrollment and demonstrate continued compliance.

601.1 **General Conditions**

A. **Legal Right to Perform Business in the State of Georgia** –

B. **Authorization Document** - The provider agency, if incorporated, must submit to the CCSP and DCH a copy of its Good Standing Certificate of Existence from the Office of the Secretary of State. **The provider agency must also submit its current business license and/or other proof of legal authorization to conduct business in the State of Georgia. Rev. 7/1/13, 1/1/14**

C. **Licensure** - If state or local law requires licensure of the agency, organization, facility or staff for the service the agency wishes to provide, the provider agency must submit proof of licensure to the Division of Aging Services, upon application **and by request thereafter**. The provider agency must post current licensure and permits (if applicable) in a conspicuous location open to public view. Licensure requirements for each service are included in each specific service provider manual. **Rev. 1/1/14**

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**NOTE:**

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In accordance with Section 105 of Part I Policies and Procedures For Medicaid/Peachcare for Kids, providers must be fully licensed without restriction. **Provisional licenses are not acceptable.**

**Rev. 1/1/14**

**D. Compliance with Rules and Regulations** - The provider agency must comply with Part I Policies and Procedures For Medicaid/Peachcare For Kids, the CCSP General Manual and the applicable CCSP service-specific manual(s), and with all applicable federal, state and local laws, rules, and regulations. (See Section 600 of the CCSP General Manual).

**Compliance** - Neither the provider agency nor its owner(s) or management may be currently under suspension from accepting CCSP referrals or delivering services in any Medicaid program.

In addition, the provider agency must have had no deficiencies within the past three years from any licensing, funding or regulatory entity associated with enrollment in any Medicaid, Private Home Care, or Title III-funded services or with the provision of any related business, unless all such deficiencies have been corrected to the satisfaction of the imposing entity and the Division of Aging Services. **Rev. 1/1/14**

**E. Sponsor or Parent Organization** - If a provider has a sponsor or parent organization, the sponsor or parent organization must maintain full responsibility for compliance with all conditions of participation. Daily operations of the program may be delegated to a subdivision or subunit of the sponsor or parent organization.

**F. Disclosure of Ownership** - The provider must have available the names and social security numbers of all persons with direct or indirect ownership interest of five percent or more.

**G. Reports** - The provider must furnish service reports to the Division of Aging Services and the DMA as requested.

**H. Organizational Structure** - The provider must diagram a readable organizational structure, administrative control, and lines of authority for the delegation of responsibility and supervision from the administrative level to the member care level, to include names and position titles. **Rev. 1/1/14**

**I. Written Member Care Policies and Procedures** - The provider agency must have written member care policies and procedures which are reviewed at least annually, revised as needed, and address at a minimum:
1. Scope of Services Offered (See specific service manual)

2. Admission Criteria (See Sections 603. B and 605)

3. Discharge Criteria (See Sections 606.7)

4. Accepting Members Referred by Care Coordination (See Sections 603 and 605)

5. Cost Share Determination, Billing, Collection, and Refund (See Sections 606.21 and 606.22)

6. Member Protection Assurances (See Section 604)

7. Documentation in the client’s record (See Section 606.17, 606.18 and 606.19)

8. Supervision of Services and Care (See Section 606.17)

9. Emergency Information (See Section 606.12)

10. Personnel Code of Ethics (See Section 607.3 C)

11. Clinical Records Management (See Sections 601.5 and 606.4, and 606.5)

12. Use and Maintenance of Supplies and Equipment (if applicable)

13. Medications (if applicable) (See Section 606.9)

14. Coordination of Member Care with Physicians, Care coordinators, and Other Providers (See Section 606.2)

15. Scheduling of Staff, including sufficient coverage when scheduled staff is unable to work (See Sections 601.1 J, K, L, M and 607)

16. Staff Orientation, Training, and Development (See Section 607.5)

17. Personnel Policies (See Section 601.1J and 607.3 )

18. Member’s Rights and Responsibilities (See Section 604.1)

19. Infection Control (Section 607.5, Appendix Q)

20. Discharge planning (See Section 606.6 and 606.7)
21. Program Evaluation (See Section 609)

22. Disaster preparedness (see Section 608)

23. Critical Incident Reporting (See Section 601.1)  **Rev. 1/1/14**

**NOTE:**
Refer to specific services manuals for additional required policies and procedures.

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**Rev. 07/10**

Provider agency policies and procedures must be clear and concise with regard to the specific agency guidelines and instruction to agency staff. The provider agency policies and procedures must also reflect a clear understanding of the CCSP and program requirements.

**Rev. 04/08**

J. **Subcontracting** - Provider agencies may subcontract for the provision of services as long as the subcontract contains, at a minimum, the following elements:

1. Names of all parties entering into the subcontract

2. A stipulation requiring subcontractor’s to perform in accordance with all Conditions of Participation which pertain to the service purchased under subcontract, and requiring the contractor to assume responsibility if the selected subcontractor fails to do so

3. A stipulation requiring the contractor agency to maintain responsibility for and assure the subcontractor's performance of administrative, supervisory, professional and service delivery responsibilities relative to meeting all requirements of the CCSP

4. A stipulation that the subcontractor will comply with local, state and federal laws, rules and regulations and will adhere to CCSP policies and procedures as they now exist or may hereafter be amended

5. A statement identifying the party responsible for paying employment taxes

6. A stipulation that the persons delivering services meet minimum staff qualifications

7. Identification of the specific CCSP service(s) to be provided

8. A stipulation that the subcontractor will participate as needed in case conferences to coordinate member care

9. Termination procedures, including an escape clause and the subcontractor’s signed agreement that they received an...
explaining the advantages and disadvantages of a short-term or long-term contract.  

A sample of all subcontracts for provision of CCSP services must be submitted to the Division of Aging Services for prior approval and a copy maintained in the provider agency's office. Any changes in above contract terms must be resubmitted to the Division of Aging Services.

K. Service Contracts/Agreements - If providers require members to sign a service contract or other binding written agreement before receiving services, the service agreement will be in a format that the member can read and easily understand. The agreement may not require members to waive their legal rights.

NOTE:
A member cannot be held liable for damage caused by normal wear and tear of provider's furniture and equipment.

L. Staff Qualifications - The provider agency must engage a sufficient number of qualified and experienced staff to render services in accordance with currently accepted standards of medical practice. The provider agency must have criteria-based job descriptions that clearly list required minimum qualifications, training, and experience. Criteria-based job descriptions must include specific tasks, job responsibilities, and duties for each staff position. A job description, signed and dated by the employee, must be maintained in each personnel file. (Refer to specific service manuals for program requirements related to staffing.)

M. Staffed Business Hours - The provider agency must be open for business with staff available at least 8 hours per day Monday through Friday.

1. Business Hours - The provider agency must maintain regularly scheduled business hours and must have in place a means to assure easy, local or toll-free telephone access to a responsible individual able to assist with information and support as needed. Providers must provide an active on-call service that coordinates dependably with care coordinators, members, and members’ families/representatives.

2. Service Availability - The provider agency must be able to provide services 24 hours a day, seven days a week, including holidays, if required or needed by the member. A supervisor must be available at all times to staff members who are rendering services. If a provider is unable to provide services as indicated in
the member’s care plan or when requested by the member, the care coordinator will broker/re-broker services with another provider who can meet the member’s needs. Exception: Adult Day Care Centers and Home Delivered Meal providers are not required to deliver services 24 hours a day.

3. **Access** - All providers must have a **local or toll-free published telephone number** for members and care coordinators to access and report problems with service delivery. PSS, RC, ALS, HDS, SNS and ERS providers must provide telephone access to enable members to call 24 hours a day, seven days a week, including holidays. Toll free numbers that require an access code may not be used.

4. **30-Minute Response** - The provider agency must respond to calls from members/representatives and/or families requesting assistance, within 30 minutes of the contact.

N. **Office Space** - Each provider, with the exception of emergency response services (ERS) providers, must maintain business premises within the State of Georgia. The provider is responsible for ensuring compliance with all local zoning ordinances. The business premises must be appropriate to conduct the CCSP program and must include (Rev 7/12):

1. A separate office which provides privacy for visitation by members, member’s families/representatives, employees, program auditors, care coordinators and other business visitors.

2. The office provides for the maintenance and storage of confidential member records.

3. A designated separate, professional office, if located in a personal residence that is used exclusively as a business office with a separate business telephone line.
   - The office must have a designated means of public access, remote from the personal residence entrance/exit, and must ensure adequate parking for visitor.
   - Branch offices must meet the same physical requirements as those described above. Branch offices are not required to have full-time staff, but the provider must be accessible to members, employees and the general public by telephone at the primary office.
O. Member Protection Assurance – All CCSP providers, their employees, subcontractor’s, and volunteers are mandated reporters of suspected or actual abuse, neglect, exploitation, elopement, unexpected death, serious injury and any other critical event/situation that has or may place a member’s health, safety, and welfare in jeopardy or at risk. Refer to Section 604.1 and Appendix EE of the CCSP General Manual.

All CCSP providers are required to:

- Have written policies and procedures that address steps the agency takes to prevent abuse, neglect, and/or exploitation; action the agency takes when such incidences are reported; and action the agency takes to prevent future occurrences of such incidences
- Screen each potential employee for criminal background history
- Prohibit individuals with a prior conviction on charges of abuse, neglect, mistreatment or financial exploitation from performing direct member care duties
- Provide training at least annually to all employees, subcontractor’s, and volunteers on how to recognize situations of possible abuse, neglect, exploitation, and/or the likelihood of serious physical harm to individuals who receive services through the CCSP
- Observe at least annually staff providing direct care to members
- Report all allegations of mistreatment, abuse, neglect, exploitation, elopement, unexpected death, serious injury, injuries of unknown origin, and any other critical event/situation immediately (within 24 hours of the event) to the administrator and to other officials in accordance with state law (Appendix EE)
- Provide for thorough investigation of all alleged member protection violations
- Prevent further potential abuse while the investigation is in progress
- Complete the investigation within five (5) business days of the incident and submit a written report of the findings to the administrator or designated representative and to other officials in accordance with state law (Appendix EE)
- Prevent further potential abuse, etc., while the investigation is in progress
- Take appropriate actions if alleged violation is verified

Providers, their employees, subcontractor’s and volunteers shall be familiar with and shall be able to recognize situations of possible
abuse, neglect, exploitation, and/or likelihood of serious physical harm to individuals who receive services through the CCSP.

- **Abuse** – is defined as any intentional or grossly negligent act or series of acts or intentional or grossly negligent omission to act which causes injury to a client, including but not limited to assault or battery, failure to provide treatment or care, or sexual harassment of the client. Abuse may be mental, verbal, sexual, or physical.

- **Neglect** – is defined as the failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness.

- **Exploitation** – is defined as an unjust or improper use of another person or the person’s property through undue influence, coercion, harassment, duress, deception, false representation, false pretense, or other similar means for one’s own profit or advantage.

- **Mistreatment** – is defined as any behavior or practice that has the potential to or results in any type of individual exploitation.

- **Unexpected Death** – is defined as death that occurs suddenly when the individual is in apparent good health or as the result of homicide, suicide, or accident.

- **Serious Injury** – is defined as bodily injury that involves a substantial risk of death, unconsciousness, extreme physical pain, sexual assault, violence, protracted and obvious disfigurement or impairment.

- **Elopement** – is defined as a cognitively impaired person successfully leaving a facility unsupervised and undetected.

Providers immediately (or no later than the close of the next business day) verbally report incidents to the Care Coordination office in the following circumstances:

**Critical Incidents** include, but are not limited to:

- Unauthorized or inappropriate touching of a member such as pushing, striking, slapping, pinching, beating, fondling
- Use of physical or chemical restraints
- Withholding food, water, or medications unless the member has requested the withholding
- Psychological or emotional abuse (i.e., verbal berating, harassment, intimidation, or threats of punishment or deprivation)
Isolating member from member’s representative, family, friends, or activities
- Sexual harassment, exploitation, or rape
- Failure to provide basic care or seek medical care
- Ostracizing the member or “giving the silent treatment”
- Inadequate assistance with personal care, changing bed linen, laundry, etc.
- Taking a member’s money or property by force, threat, or deceit
- Use of a member’s money or property against the member’s wishes or without the member’s knowledge
- Leaving member alone for long periods of time
- Elopement
- Sudden death

Reportable Critical Events include:
- Alleged criminal acts by staff against a client or DHS ward
- Alleged criminal acts which are reported to the police by a person who receives services
- Client or DHS Ward missing without authority or permission and without others’ knowledge of whereabouts
- Financial exploitation or mismanagement of client funds
- The intentional or willful damage to property by a client that would severely impact operational activities or the health and safety of the client or others
- Whether by a client or staff person on duty or other person, any threat of physical assaults, or behavior so bizarre or disruptive that it places others in a reasonable risk of harm or, in fact, causes harm
- Inappropriate sexual contact or attempted contact by a staff person (on or off duty), volunteer or visitor, directed at a client receiving services funded by a federal, state, or local public authority

NOTE: ALS and ADH providers will complete an incident report of any event/situation that has placed the client’s health, safety, and/or welfare in jeopardy or at risk. If an incident that occurs in an ADH involves a member who resides in an ALS, the provider must also notify the ALS. (Rev. 10/14) All other service providers will complete an incident report of such events/situations if any of their staff were present at the time of the incident or were a part of the incident. Interventions must be specific to the client’s cognitive, physical or mental impairment and target reduction of risk for client injury and reduce risk of
Within three days of the verbal notification of the incident to the Care Coordination office, providers will submit a follow-up Community Care Notification Form (CCNF) to the care coordinator.

The care coordinator will submit applicable documents related to the incident to the Division of Aging Services, CCSP. The CCSP will use this information as a quality management strategy to identify trends and to implement system-wide improvement strategies.

P. Standard Assurances - The provider agency may not discriminate or permit discrimination against any person or group of persons on the grounds of age, race, sex, color, religion, national origin, handicap, or member's failure to execute advance directives. All providers are required to submit a signed and dated Standard Assurance, Assurance of Compliance with Title VI of the Civil Rights Act of 1964 and Letter of Understanding signed by the person legally authorized to act for the agency or person to whom responsibility for these assurances is delegated. The necessary forms are included in the enrollment packet.

Q. Communication with Area Agencies on Aging (AAA) – The applicant agency must conduct a face-to-face visit with the Area Agency on Aging Director(s) of each Planning and Service Area (PSA) where the applicant is seeking to initiate services. The applicant agency will consult with the AAA in order to learn about the aging network in the PSA and to gain assistance with the provider's market analysis. (See Appendix A.) Providers enrolled in the CCSP are required to attend at least two of four quarterly AAA Network Meetings during the state fiscal year (July 1 – June 30) in the Planning and Service Areas (PSA) in which services are being rendered. Providers who serve more than one PSA region must meet their network meeting attendance requirement by attending meetings in different regions in different calendar quarters. Refer to attachment “A “for the counties served by the 12 PSA’s. The minimum network meeting attendance requirement can consist of participation via Webinar, when available, for one meeting, and attendance in person at another meeting. (Rev. 7/1/13, 10/1/13, 4/1/14 and 1/1/2015)

NOTE:
Refer to Section 601.3 D if applicant is a current CCSP provider.

R. Accepting Referrals - The provider agency must accept all appropriate referrals from CCSP care coordinators, including members who are currently Medicaid eligible or potentially Medicaid eligible.
S. **Member Referrals** - The provider agency must understand that approval for enrollment in the CCSP does not guarantee referrals. Care coordinators make referrals to enrolled providers based on member choice, rotation, and availability of CCSP funding. **Providers are encouraged to secure funding sources other than Medicaid.**

T. **Disclosure** - If any agency knowingly fails to disclose all requested information or provides false information, the Division of Aging Services will not recommend approval of enrollment to the DMA. If at any time following enrollment a provider agency is found to have falsified or knowingly failed to disclose application information, the Division has the right to recommend that provider's termination from the CCSP.

U. **Alzheimer's Disclosure Form** - Any provider agency that advertises, markets, or offers to provide specialized care, treatment, or therapeutic activities for one or more persons with a probable diagnosis of Alzheimer's Disease or Alzheimer's-related dementia is required to complete the Alzheimer's Disclosure Form. (Refer to Appendix H.)

V. **Enrollment Training** – The applicant must attend Provider Orientation Training. See 601.2 C 5 of this manual for details. **Rev. 1/1/14, 4/1/14**

W. **HIPAA Compliance** – All applicants/providers must demonstrate compliance with the Health Insurance Portability and Accountability Act of 1996. (For additional information refer to www.communityhealth.state.ga.us.)

X. **Business Experience** – All applicants must submit proof of business experience. **See 601.2 B 1 n for details. Rev. 4/11, 1/14, 4/14**

Y. **Insurance Coverage**- The applicant must submit proof that the provider agency has at least $1,000,000 in general liability insurance coverage. Private home care providers must submit proof of their agency’s worker’s compensation insurance coverage. **Rev. 1/1/14**

Z. **Electronic Mail**- The applicant must maintain a professional, business electronic mail address

601.2 **New Provider Enrollment** (revised 4/1/2014, 1/1/2015))

New provider enrollment is accomplished in a three (3) step process:

1. Information Session (Optional)
2. Pre-Qualification Process
3. CCSP Medicaid Provider Application Process

Enrollment cycles will occur two (2) times per year. Pre-qualification materials will be accepted during the specified month of the enrollment period. All providers must meet the requirements of pre-qualification to be considered for further review.

A. Information Session for Potential Providers

The Division of Aging Services will host a CCSP Enrollment Information Session prior to the beginning of each recruitment cycle. The information session includes a review of enrollment requirements and a question and answer session. Attendance is not required.

Please visit our website http://aging.dhs.georgia.gov/documents/become-medicaid-provider for schedule and registration procedures.

B. Pre-Qualification Process

The Division of Aging Services utilizes a Pre-Qualification determination process to review provider applicants for CCSP services. Applicants who meet the Pre-Qualification requirements are invited to continue to the next screening level.

Interested providers must submit Pre-Qualification documents, as specified in Section C.1 below, during a specified recruitment cycle. All applicants must meet the requirements of pre-qualification to be eligible to submit an application packet. Pre-Qualification documents postmarked after the last day of the recruitment cycle will be returned without review and may not be resubmitted until the next scheduled recruitment cycle.

Recruitment cycles are as follows:

- March 1st - March 31st
- September 1st – September 30th

1. Required Pre-Qualification Documents

   a. A Notice of Intent to Become a CCSP Service Provider (Appendix FF) (Rev 7/2014)
   b. Resumes for the following agency personnel:
      - Owner(s)
      - Director
      - Lead/Supervising Registered Nurse (RN)
   c. The organization’s current Secretary of State Certificate of Good Standing
   d. The applicant organization’s current/valid business license
e. An IRS Letter 147C or Form SS4 to verify the organization’s legal name and federal tax ID
f. Proof of $1,000,000 General Liability Insurance coverage
g. Proof of Workers’ Compensation Insurance coverage (personal support, skilled nursing and home delivered services providers only).
h. Current license issued by the Georgia Department of Community Health, Healthcare Facilities Regulation Division (adult day health, personal support, skilled nursing, home delivered services and group model alternative living services provider only). Provisional permits are not accepted. (Rev 1/2015)
i. A business plan, including a plan of comprehensive supervision, including nursing supervision, for sub-contracted personal care home (alternative living services-family model providers only) (Rev 1/2015)
j. A copy of a sample contract your agency plans to use to sub-contract with family model personal care homes (alternative living services-family model providers only) (Rev 1/2015)
k. A letter from an Area Agency on Aging verifying a current contract to deliver services under a Title III or Social Services Block Grant funded meals program (home delivered meals providers only)
l. Specifications for all types of equipment used for emergency response (emergency response system providers only) (Rev 1/2015)
m. A copy of the current Georgia state license for the applicant organization’s lead/supervising registered nurse (RN) (Not required for emergency response system or home delivered meals providers)
n. The most recent inspection documents, free of deficiencies, from the following agencies, as applicable to your organization:
   - Georgia Healthcare Facilities Regulation Division (HFRD)
   - Local fire department
   - DCH Utilization Review (current Medicaid providers only).

  o. A signed and notarized affidavit certifying a minimum of twelve (12) months experience for the applicant in the service for which the organization intends to make application for enrollment as a provider
  p. The agency’s most recent self-evaluation results
  q. Alzheimer's Disclosure Form (if applicable) manual ref. 601.1Q

2. Submission Process
a. All pre-qualification documents must arrive in hardcopy format, with each section tabbed and identified. Fax and e-mailed documents cannot not be accepted.
b. Documents must be organized in order of the check list provided in Appendix GG.
c. Submit all pre-qualification documents via US Postal Service certified mail - return receipt requested, FedEx, or UPS delivery to the address listed below.

Department of Human Services
Division of Aging Services (DAS)
Community Care Services Program
Two Peachtree Street, NW
Suite 33-427, Provider Enrollment
Atlanta, Georgia 30303-3142

d. The organization’s email address specified in the Pre-Qualification documents must be valid and able to accept emails from CCSPMessages@dhr.state.ga.us, as this will be the main form of communication between the Division of Aging Services (DAS) and the applicant. It is the responsibility of the applicant to ensure that emails from DAS are accepted by their email system and do not go to the “spam” mailbox.

3. **Response to Pre-Qualifiers**

   a. DAS will send, via email, an acknowledgment of receipt within 3 business days of the date Pre-Qualification documents are received at DAS.
   b. If ALL Pre-Qualification documents are not submitted, the application will be withdrawn without review and cannot be resubmitted until the next recruitment cycle. **Documents for withdrawn applications will not be returned. (Rev 1/2015)**
   c. By the 15th of April for the first recruitment cycle, or the 15th of October for the second recruitment cycle, DAS will notify the applicant of any deficiencies identified. Pre-Qualification applicants will be notified of their ONE (1) opportunity to submit corrections and shall be given at least 2 weeks (14 days) from the date of notification to submit corrections.
   d. Pre-Qualification approval decisions will be made on or before May 1st for the first cycle and November 1st for the second cycle.
      i. If the Pre-Qualification documents are free of deficiencies, a CCSP Medicaid provider application packet will be emailed to the applicant.
      ii. If the Pre-Qualification documents are not free of deficiencies, they will be returned and cannot be resubmitted until the next recruitment cycle.

C. **CCSP Medicaid Provider Application Process**

A packet of CCSP Medicaid application documents, referred to hereafter as the application packet, will be sent via e-mail to the applicant organization once Pre-Qualification documents are accepted as complete.
1. Required Application Documents

   a. A check or money order for a non-refundable $200 application fee made payable to “DAS Healthy Aging Trust Fund”  (Rev 1/2015)

   b. Completed AAA Consult Form (Appendix Y)  Rev 7/2014

   c. Department of Community Health Facility Enrollment Application (Complete online at www.mmis.georgia.gov at “Enrollment Wizard” in the dropdown box under “Provider Enrollment.”)  (Rev 1/2015)

   d. Disaster Plan

   e. Signed and dated Standard Assurance

   f. Signed and dated Assurance of Compliance with Title VI of the Civil Rights Act of 1964

   g. Signed and dated Letter of Understanding

   h. Signed and dated Letter of Agreement (ALS only)

   i. Electronic funds transfer agreement with voided check attached

   j. Completed and signed IRS Form W-9 for your company. (Enter company info only, not your name or SSN.)  (Rev 1/2015)

   k. Policies and Procedures for your organization, as outlined in Section 601.1 I of this manual.  *This item may be requested in the application packet or viewed at the site visit, at the discretion of the DAS provider specialist who is assigned to process the application.*

2. Submission Process

   a. The application packet must be completed and returned to DAS within 2 weeks (14 days) from the date of the email from DAS that sent the application packet materials.

   b. The completed application packet must be submitted in hard copy (no faxes or e-mails), tabbed and organized in the order of the checklist provided in Appendix HH of this manual.

   c. Applications postmarked after the due date will be returned without review and cannot be resubmitted until the next application cycle.

3. Review of the Application Packet

   a. DAS will email the applicant an acknowledgment of receipt within 3 business days of the date the application packet is received.

   b. If ALL Pre-Qualification documents are not submitted, the application will be withdrawn without review and cannot be resubmitted until the next recruitment cycle.  *Documents for withdrawn applications will not be returned.*  (Rev 1/2015)

   c. DAS will notify the applicant of any deficiencies within 30 calendar days of receipt of a complete application packet.
d. Applicants will be notified of their ONE (1) opportunity to submit any needed corrections and will be given at least 2 weeks (14 days) from the date of notification to submit corrections.

e. When the application packet is determined to be free of deficiencies, a site visit may be arranged.

4. Site Visit

All applicants may have a site visit of their facility conducted by a Division of Aging Services Program Specialist. The only exception is for ERS provider agencies located out of state. The site visit may include but is not limited to the following:

a. A tour of the facility
b. A review of organization’s policy and procedure manual
c. Observation of the client and personnel record storage system
d. Interviews with available agency staff
e. Observation of general operations

5. Provider Orientation Training

a. Prior to being assigned your Medicaid provider number, you will be required to attend a Provider Orientation training session. You will receive an invitation to this training from DAS once you have completed the enrollment process and the decision has been made to recommend enrollment. Failure to attend Provider Orientation training will result in a recommendation to deny enrollment.

b. Existing CCSP providers applying for a new CCSP service may have this training requirement waived at the discretion of the Division of Aging Services.

6. Enrollment Decision

a. If the DAS provider specialist determines the applicant organization is qualified to be a provider after a careful review of the application packet, a successful site visit, and the provider’s attendance at Provider Orientation Training, the provider specialist will send a letter of recommendation of enrollment to the Department of Community Health’s (DCH) Medicaid Division, along with all documents from the application packet that are required to assign a Medicaid provider ID.
b. If the DAS provider specialist determines the provider has not completed the application process or is otherwise not qualified to be a provider, the provider specialist will send a letter of recommendation of denial of enrollment to DCH.

7. Notification of Enrollment Decision

a. The Division of Aging Services will notify the Area Agencies on Aging and Care Coordination agencies of the approval of the application, with a copy of the notification sent to the applicant. This notification will include the newly assigned Medicaid provider ID and the effective date.

b. The Department of Community Health will notify the organization if the application is denied. This notification will include the reason for denial and appeal rights, as stated in Part I, Policies and Procedures for Medicaid/Peachcare for Kids Manual.

c. If the application is denied, the applicant will not be permitted to re-apply for a period of one (1) year from the date of the denial.

d. If at any time during the enrollment process or following enrollment a provider agency is found to have falsified or knowingly failed to disclose application information, DAS will exercise their right to recommend the provider agency be denied enrollment or terminated as a CCSP Medicaid provider.

601.3 Expansion Procedures for Active CCSP Medicaid Providers (revised 4/1/2014, 1/1/2015)

A. Adding a CCSP Service or an Additional Location for an Existing Service

1. Active CCSP Medicaid service providers must submit an enrollment application in accordance with Section 601.2 of this manual for each additional service.

2. A provider who is requesting to expand into a new service must have been an active CCSP Medicaid Provider for a minimum of 12 months.

3. Active CCSP Medicaid service providers who are adding an additional service location for an existing service must submit a Department of Community Health Facility Enrollment Application or Additional Location Application (online), plus a copy of their current HFRD license, most recent clean HFRD inspection report, local business license and proof of current liability/worker’s comp insurance coverage. (Rev 1/2015)

4. The $200 application fee is waived for active CCSP service providers who are applying to add a new service or an additional location for an existing service. (Rev 1/2015)

B. Expanding the Service Area of an Existing Service
1. Providers wishing to expand the geographical area that an existing, Medicaid enrolled office serves must submit a **Service Expansion Application** (Appendix B). This application must be submitted according to the guidelines identified here.

2. A Medicaid Facility Enrollment Application must be completed if the expanded area will be served from an office that is not currently enrolled.

   a. Service Area Expansion applications are **not accepted** during new the provider enrollment review months of March, April, September and October.

   b. Applications received in months these months will be **withdrawn** without review.  
      **Rev 1/2015**

   c. Providers seeking service area expansion must have been active CCSP Providers for a minimum of twelve (12) months.

   d. Neither the provider agency nor its owner(s) or management may be currently under adverse action in any Medicaid program.

   e. The provider agency must have no deficiencies within the past three years from any licensing, funding or regulatory entity associated with Medicaid, Private Home Care or Title III-funded services. If deficiencies are cited, they must be corrected to the satisfaction of the imposing entity.

C. **Service Expansion Application Review**

   a. Within 3 business days of receipt of the Application documents, DAS will send an emailed acknowledgment of receipt.

   b. If ALL required documents are not submitted, the application will be **withdrawn without review. Rev 1/2015**

   c. Within 30 calendar days of receipt of the application documents, DAS will notify the applicant of any deficiencies.

   d. Applicants will be notified of their ONE (1) opportunity to submit any needed corrections and will be given at least 2 weeks (14 days) from the date of notification to submit corrections.

   e. The agency may receive a site visit as part of the application review process.

   f. Within 45 days of receipt of the Application documents, a decision regarding the submitted documents will be made, with notification to the applicant following the procedures outlined in section 601.2 C 7 of this manual. 
      Final decisions on whether to approve a request to expand a service area are made by the Department of Community Health.

   g. If the expansion is denied, the applicant will not be permitted to re-submit a service area expansion application for a period of 6 months from the date of the denial.

601.4 **Change in Enrollment Data**

   A. Change of Ownership or Legal Status or Buy Out

      1. New Providers purchasing an existing business with a current provider number

   **Rev. 07/09**
a. The purchasing entity must **first** become an enrolled CCSP provider by following the policies and procedures as set forth in Chapter 600, Section 601.2 while also following Federal Guidelines as stipulated 42 C.F.R. § 442.14 (further clarification can be found in Part I Medicaid/PeachCare for Kids Policies and Procedures, Chapter 100, Section 105.)

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NOTE
Rev. 10/09
If the existing business is currently serving CCSP clients, please refer to #3-Interim Reimbursement found in this section.
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2. **Required Notification:**

Any enrolled provider undergoing a change (including, but not limited to, dissolution, incorporation, re-incorporation, reorganization, change of ownership of assets, merger or joint venture) that results in the provider either becoming a different legal entity or being replaced in the CCSP by another provider, must:

Give the Division of Medical Assistance ten (10) day prior **written** notice before affecting a change such as dissolution, incorporation, re-incorporation, and reorganization, change of ownership of assets, merger, or joint venture where by the provider becomes a different legal entity or is replaced in the program by another provider. The successor provider must submit an executed Statement of Participation to become effective at the time of the above-described change. Failure of the successor to execute a new Statement of Participation will prevent the Division from reimbursing any further services as of the date of the change.

Provide **written** notice of intent to sell or change ownership or legal status must be given at least thirty (30) days prior to the date of the change to:

- CCSP Members
- Care coordinators
- Area Agency on Aging
- Division of Aging Services, CCSP
- Healthcare Facility Regulations Division, if applicable

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Rev. 10/09
Rev. 04/08
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Refer to Sections 105.7 and 105.8 of **Part I Policies and Procedures** for notifying the Division of Medical Assistance of a change of ownership or legal status.

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NOTE:
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If the new legal entity chooses not to enroll in the CCSP, services will be rebrokered to an enrolled CCSP provider within thirty (30) days of the effective date of the change for those members who wish to continue receiving CCSP services.

3. Interim Reimbursement:

Medicaid reimbursement for the current provider will terminate on the effective date of the sale. However, if the new owner chooses to apply for a Medicaid provider number, Medicaid reimbursement may be effective for the new owner during the period of time between the effective date of ownership and effective date of approval to enroll in the CCSP if the following conditions are met:

- The new owner/applicant submits a Letter of Intent to Division of Aging Services, prior to the effective date of ownership, with assurance that it will provide CCSP services according to all CSP Policies and Procedures.

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- The new owner/applicant submits HFR license in the new owner/applicant name or evidence that application for this HFR license has been made, if license is required.

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- The new owner/applicant submits to Division of Aging Services enrollment applications (CCSP and Medicaid) within thirty (30) days of the letter of intent. If the enrollment applications are not acceptable, the applicant will have thirty (30) days to make revisions. If, after the revision period, the revisions are not acceptable, DAS will recommend denial of the application to DCH.

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- The new owner/applicant completes 180 days of operation of the existing business during which time, no CCSP member will be admitted to the agency.

The Division of Aging Services will review the applications and provider enrollment documents, HFR survey reports, provider complaint logs, Utilization Review documents, and Ombudsman recommendations and care coordination provider check lists, if applicable. Enrollment or denial in the CCSP will be recommended to DCH. DCH will notify the applicant in writing the approval or denial of the application.

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EXCEPTION: If the new owner is currently an enrolled CCSP Medicaid service provider in good standing, please refer to policies and procedures found in this chapter, section 601.3.

4. Participation Contingency:
Participation of the new owner in the CCSP will be contingent upon the following conditions being met:

- Satisfactory completion of applications
- Satisfactory site visit by Division of Aging Services staff, if applicable

New management will be required to attend mandatory CCSP Provider Trainings.

Failure to meet above contingencies will result in the Division of Aging Services recommending recoupment of all Medicaid funds and recommending termination from the CCSP.

NOTE:
Medicaid Provider Numbers, Personal Care Home permits, Private Home Care Licenses, and Certificates of Need, are not automatically transferable. Providers are required to notify the licensing/permitting agency of any changes in ownership, legal status, or location.

Purchase of an existing enrolled provider agency requires that the purchaser complete the enrollment process and obtain a Medicaid Provider Number. Without a Medicaid Provider Number, Medicaid reimbursement will not occur.

B. Change of Provider Data

A provider must ensure that the Division of Aging Services and the DMA are provided updated, accurate information, which includes but is not limited to:

- correct address of the agency/business location
- correct street address of the service location, if different from above
- current phone number(s)
- name of contact person(s)
- data on subcontractor’s providing direct member care
- Electronic Mail Address (e-mail)

Enrolled providers are required to furnish written notice to the Division of Aging Services, the Division of Medical Assistance, the Healthcare Facility Regulations Division (if applicable), the Area Agency on Aging,
the Care Coordination agency and the CCSP members, at least 30 calendar days prior to any change in provider data. (See Section D for addresses.) Changes requiring written notice include, but are not limited to:

- address of the provider agency administrative/business office
- address of the service location
- telephone numbers
- subcontractor data changes
- change in permit/license issued by the Healthcare Facility Regulations Division

If the contact person for the administrative or service location changes, the provider must notify the Division of Aging Services within 30 calendar days of the change. (See Section D below for addresses).

Alternative Living Services, Adult Day Health, and Out-of-Home Respite Care facilities may not relocate without:

- A satisfactory site visit
- Submission of the required permits and inspections from the regulating agencies
- Submission of business license and certificate of occupancy
- Approval of the proposed location from the Division of Aging Services.

**NOTE**

CCSP will not accept a change of address notice unless the agency produces (or submits) evidence that the change of address has been validated by the Georgia Department of Community Health, Healthcare Facility Regulations Division (HFRD), if applicable, the county business office, and/or Secretary of State’s Office, prior to the request with CCSP.

C. Termination of Provider Number/Enrollment in CCSP

1. Provider-Initiated Termination

- A provider seeking to terminate enrollment in the CCSP must provide written notice to the Division of Aging Services, Division
of Medical Assistance, the Healthcare Facility Regulations Division, if applicable, and Area Agency on Aging and Care Coordination no less than 30 calendar days prior to termination date, stating that it intends to cease accepting CCSP referrals and terminate participation in the CCSP. (See Section D for addresses).

- The provider must provide written notice of discharge to CCSP members at least thirty (30) calendar days prior to the effective date of termination.

**NOTE:**
Even when the change in ownership and/or legal status results in no visible change in services to the member, the provider must inform members and care coordinators.

2. Termination of Provider Number/Enrollment by the DMA

- The DMA may suspend or terminate a provider as described in Part I, Chapter 400.
  - Failure to correct conditions that warrant suspension will result in termination from the CCSP.

D. Notice - Send notices of change in ownership/legal status, change of provider data or notices of intent to voluntarily terminate provider number/enrollment in CCSP to:

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Georgia Department of Human Services
Division of Aging Services
Community Care Services Program
Two Peachtree Street, NW
33rd Floor
Atlanta, GA 30303-3142

And

Department of Community Health
Division of Medical Assistance
Aging and Community Services Unit
Two Peachtree Street, NW, 37th Floor
Atlanta, GA 30303-3159
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and, if applicable,

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Rev 07/09, 10/09
Georgia Department of Community Health
Healthcare Facility Regulations Division - Director's Office
Two Peachtree Street, NW
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E. Response from State Agencies - The Division of Aging Services will acknowledge receipt of notice of a change in ownership/legal status within ten business days of receipt. The Division will send copies of the acknowledgment to Area Agencies on Aging Director(s) and the Division of Medicaid. The Division of Medicaid will forward all changes to Hewlett Packard (HP) (GHP).

601.5 Records Management

Providers must maintain clinical records related to the provision of CCSP services in accordance with accepted professional standards and practice and with the standards in this manual. Records must be made available to DHS, DMA and their agents as requested. The provider must maintain all CCSP records within the state of Georgia. Records are maintained in a manner that is:

- secure
- accurate
- confidential
- accessible

A. Records Retention

1. The provider must maintain current clinical records for active members and organize the clinical records for easy reference and review. For discharged members, the provider must maintain the clinical record for a minimum of six years from the last date of service. This policy applies even if the provider ceases operation (Refer to Part I, Policies and Procedures). Providers who utilize electronic signatures to validate supervision of services should refer to Part I, Policies and Procedures, Definitions #60 and Section 106 (R). (Rev. 10/2011, 1/2015) Additionally, CCSP permits electronic signatures and/or computer-generated signatures only if the supervisor’s access codes and electronic script is generated on the documents required in the member file.

2. In accordance with 45 CFR Part 17, the state and federal governments shall have access to any pertinent books, documents, papers, and records for the purpose of making audit examinations, excerpts, and transcripts. The provider must retain records for six years after submission of the final claims for payment. If any litigation, claim, or audit is initiated before the
expiration of the six-year period, the provider must retain records until all litigation, claims, or audit findings involving the records are resolved.

B. Destruction of Records

1. A provider may destroy records not required to be maintained. The destruction of records must be conducted in such a way that member confidentiality is preserved.

2. When records are accidentally destroyed, the responsible party must in a timely manner reconstruct them to the extent possible. Each reconstructed case record must be clearly labeled "reconstructed".

602. Corrective Action

602.1 Corrective Action Requested by the Division of Aging Services

A. Removal from Rotation List/Suspension of Referrals as Corrective Action

- The Care Coordination agency may recommend to the Area Agency on Aging that a provider be removed from the rotation list and have referrals suspended. The AAA or Division of Aging Services/CCSP may remove a provider from the rotation list/suspend referrals when appropriate documentation supports this action.

B. Reasons for Removing a Provider From the Rotation List/ Suspending Referrals

A provider may be removed from the rotation list and have referrals suspended for reasons including, but not limited to:

- Provider fails to accept referrals
- Provider fails to provide services as required by the comprehensive care plan
- Provider refuses to accept member because one or more of other needed services are brokered to another provider
- Provider overcharges members for services
- Provider fails to refund fees
- Provider has a documented history of confirmed complaints related to member care/issues
- Provider agency has allegations of member abuse, neglect, exploitation, and/or fraud
- Healthcare Facility Regulations Division imposes sanctions against the provider that result in limitation, suspension, restriction, or revocation of the license/permit

- Provider fails to submit requested plan of correction.

- Failure of the provider to comply with Utilization Review or failure of the provider to correct deficiencies cited as the result of an audit

- Provider fails to attend a minimum of two (2) AAA network meetings per year.

C. Definition of Removal from Rotation List/Suspension of Member Referrals

When a provider agency is removed from the rotation list, care coordination agencies will not broker any CCSP members to the provider agency and will not refer new CCSP referrals to the provider agency for a specific period of time. The provider agency may continue providing services to CCSP members currently brokered to the agency.

**NOTE:**

Care coordinators may inform members currently receiving services from the provider that the Division of Aging Services/CCSP has sanctioned the provider agency. The member may choose to continue receiving services from the provider agency or may request a new provider.

D. Procedure for Removing a Provider From the Rotation List/Suspension of referrals

The AAA or Division of Aging Services/CCSP will notify the provider in writing that the provider agency has been removed from the rotation list and that all referrals have been suspended and the reason(s) for the corrective action. The written notice will include the effective date of the removal from the rotation list/suspension of referrals, the duration of the corrective action, the request for a written plan of correction within fifteen (15) working days, the time frame in which the provider is to correct the deficiencies, and the appeal process should the provider disagree with the corrective action imposed.

**Failure to submit the written plan of correction may result in additional adverse action.**

The duration of the removal from the rotation list/suspension of referrals will be imposed for a specific time period. For the first offense, a minimum of three (3) months will be imposed; for subsequent offenses, a minimum of six (6) months will be imposed. The AAA or Division of
Aging Services/CCSP may shorten or lengthen the duration of the corrective action, depending upon the reason for the action.

NOTE:
If a provider agency is removed from the rotation list / had referrals suspended two or more times within a twelve (12) month period, the Division of Aging Services/CCSP will recommend to the DCH appropriate adverse action.

E. Due Process

The provider shall have ten (10) days from the date of the written notice of removal from the rotation list/suspension of referrals from the AAA or DAS/CCSP to submit a written request for an Administrative Review. All requests for reviews must be submitted to the address specified in the corrective action notice to the provider. The written request for an Administrative Review must include all grounds for appeal and must be accompanied by any supporting documentation and explanations that the provider wishes the Division of Aging Services/CCSP to consider. Failure of the provider to comply with the requirements of administrative review, including the failure to submit all necessary documentation, within ten (10) days shall constitute a waiver of any and all further appeal rights, including the right to a hearing, concerning the matter in question.

The Division of Aging Services/CCSP shall render the Administrative Review decision within thirty (30) days of the date of receipt of the provider's request for an Administrative Review.

Following an evaluation of any additional documentation and explanation submitted by the provider, a final written determination regarding removal from the rotation list/suspension of referrals will be sent to the provider. If the provider wishes to appeal this determination regarding removal from the rotation list/suspension of referrals, the provider may appeal the decision of the Director of the Division of Aging Services. The appeal must be in writing and received by the Director’s office within ten (10) business days of the date the Administrative Review decision was received by the provider. The appeal shall be determined within forty-five (45) days of the date on which the Director's office received the request to appeal.

The request for the appeal must include the following information:

- A written request to appeal the decision of the Administrative Review
- Identification of the adverse administrative review decision or other Division action being appealed
o A specific statement of why the provider believes the administrative review decision or other Division action is incorrect; and

o Submission of all documentation for review

An appeal shall not stay the action appealed.

The Director of Division of Aging Services will reach a decision within forty-five (45) days of receiving the appeal. If the Director's decision upholds that of the Division of Aging Services/CCSP, removal from the rotation list/suspension of referrals shall remain in effect for the time specified.

The decision of the Director, Division of Aging Services, is final. No further appeal rights will be available to the provider.

F. Reinstating to the Rotation List/Referrals

If the provider submits the required plan of correction within the time frame specified in the written notice of removal from the rotation list/suspension of referrals and demonstrates that the deficiencies have been corrected, the AAA or Division of Aging Services/CCSP will notify the provider that the agency has been reinstated to the rotation list and may receive referrals. The AAA or Division of Aging Services/CCSP will notify the care coordination agency when the provider has been reinstated to the rotation list and may receive referrals.

G. Failure of Provider to Correct Deficiencies

If the provider fails to submit the required plan of correction and fails to demonstrate that deficiencies have been corrected, the provider will remain off the rotation list/suspension of referrals and the Division of Aging Services/CCSP will recommend further actions to the Department of Community Health (DCH) including re-brokering of services with another provider and termination of the provider's enrollment in the CCSP.

602.2 Complaints

If a complaint is referred to the Division of Aging Services and, after initial scrutiny, appears to involve criminal activity or lack of program integrity, the Director of the Division of Aging Services shall have the discretion to refer the complaint to the Georgia DHS Office of Investigative Services, the Department of Community Health (Program Integrity), law enforcement agencies, and other regulatory entities.

602.3 Serious and Unusual/Unexpected Incidents/Emergencies
In the event of allegations of abuse, neglect, exploitation, fraud, and/or member health, safety, and/or welfare are at risk or in immediate jeopardy, and the provider agency has failed to act appropriately, the Care Coordination Agency will immediately notify the Area Agency on Aging. The Area Agency on Aging will notify the Division of Aging Services/CCSP of the incident.

When there is the threat of immediate jeopardy to the health, safety, and/or welfare of a member, the Division of Aging Services/CCSP will immediately notify the Care Coordination agency to relocate CCSP members, if appropriate. The Division of Aging Services/CCSP will notify the DCH within 24 hours that care coordination has been instructed to relocate members due to their health, safety, and/or welfare being at risk. The Division of Aging Services/CCSP will recommend to the DCH appropriate adverse action.

Depending upon the nature of the incident, the provider may be asked to submit specific policies and procedures for review by the Area Agency on Aging and/or Division of Aging Services/CCSP to determine if the provider agency followed policy and standard of practice.

602.4 Adverse Action

A. Conditions of Adverse Action

The DCH has authorized the Division of Aging Services/CCSP to recommend adverse action that requires enrolled providers to correct deficiencies. Adverse actions may be imposed independently or in conjunction with other regulatory agencies. (Refer to Part I, Policies and Procedures, and Section 601.1D of the CCSP-General Manual).

The DCH/DMA determines the adverse action and notifies the provider agency and CCSP of its decision and notice of action.

B. Reasons to Impose Adverse Action

The Division of Aging Services/CCSP will recommend the adverse action(s) it believes will most likely achieve correction of the deficiencies cited. The Division of Aging Services/CCSP may recommend adverse action for reasons including, but not limited to:

1. Failure to Accept Referrals – The provider agency fails to accept referrals made for approved planning and service areas, in accordance
with stated service hours, or the agency fails to provide the Area Agency on Aging written reasons for failure to accept referrals.

2. **Pattern of Non-Compliance With Policies and Procedures** – A pattern of non-compliance is established if the provider agency is cited for policy violations within the previous three (3) years. A pattern of non-compliance is determined through:

- Utilization Review Reports or other audits conducted by the Division of Medical Assistance;
- reviews and site visits conducted by the Department of Community Health, Healthcare Facility Regulations Division (HFR) and/or its agents;
- and/or reports from members, members’ representatives, member families, Area Agencies on Aging, and/or care coordination.

The provider agency must notify the Division of Aging services/CCSP in writing of any non-compliance, even if temporary, as soon as it occurs (i.e., resignation of a required staff member) to request a temporary written waiver from the Division of Aging Services/CCSP.

3. **Failure to Render Services** – Failure of a provider agency to provide services as required by the care plan in accordance with currently accepted standards of medical practice, including the provision of nursing supervision.

If the provider agency experiences temporary staffing problems and is unable to provide services as required by the member's care plan, the provider must immediately notify the care coordinator. If the problem is expected to continue more than ten (10) business days, or the member's condition is such that a delay/interruption of service would be a disservice to the member, the care coordinator will re-broker the member's services with another provider.

4. **Failure to Maintain Quality of Care** – Care and/or services provided are of such quality that the health, safety and/or welfare of members are placed at risk.

5. **Refusal to Accept Member** – Refusal by a provider agency to accept a member because of one or more of the other services needed by the member is brokered to another provider or because the member has cost share liability.

6. **Failure to Maintain Current Licensure** – Failure of provider agency to maintain current licenses for the agency and personnel as required by
Georgia law. A provisional permit may be accepted for no longer than six months from the date of issue. Failure of the provider agency to become fully licensed and submit evidence of that licensure within six months from the date of issue of the provisional permit will result in termination of the Medicaid provider number.

7. **Failure to Act on Charges of Abuse, Neglect, and/or Exploitation of Members** – Failure of a provider agency to take measures to stop identified known abuse, neglect, and/or exploitation of members.

8. **Relocation Without Prior Approval and Notification** – Moving members from an Adult Day Health Center, a Respite Care Facility, or an Alternative Living Services facility without obtaining prior approval of the Division of Aging Services/CCSP or without furnishing sufficient prior notice to the CCSP member(s), member representative(s), and care coordinator(s).

9. **Failure to Respond to an Adverse Action** – Failure of a provider agency to submit a timely plan of corrective action or any other reports or documentation as requested or required by the Division of Medical Assistance and/or Division of Aging Services/CCSP.

10. **Refusal of Access to Member and Member Records** – Failure of a provider agency or its subcontractor(s) to permit staff or contracted personnel acting on behalf of the State of Georgia access to members, member records or other documentation required for participation in the CCSP.

11. **Falsification of Records or other Acts of Fraud/Abuse**

12. **Inappropriate Charging** – Willful overcharging of members and/or their representative(s) for services.

13. **Failure to Refund Fees** – Failure of a provider agency to refund fees to members after a determination that a member is due a refund

### NOTE:
Retroactive Medicaid eligibility and/or other reasons may cause a provider to owe refunds to a member.

14. **Failure to Notify Prior to Termination** – Failure of a provider agency to provide required notice prior to termination of services. Providers who abruptly discontinue services may not request re-enrollment for a period of one (1) year from the date services were discontinued. (See Section 404.2 Part I Medicaid/Peachcare for Kids).

15. **Failure to Respond to Member's Needs for 24-Hour Service** – (See Section 601.1M of the CCSP General Manual).
C. Types of Adverse Action(s)

Types of adverse action the Division of Aging Services/CCSP may recommend to the DCH include, but are not limited to:

1. Suspension of Provider – The provider agency will be suspended from participating in the Medicaid program for a defined period of time not to exceed one year.

2. Termination of Provider Enrollment

3. Re-Brokering of Member Services – When the health, safety, and/or welfare of CCSP members is at risk and/or in immediate jeopardy, the Division of Aging Services/CCSP will notify the care coordination agency to immediately re-broker services of CCSP members to another approved CCSP provider. The Division of Aging Services/CCSP will notify DCH of the emergency re-broking of members within twenty-four (24) hours and may recommend further adverse action.

4. Delaying the processing of pending and additional provider enrollment applications and expansion requests.

NOTE:
Even in the absence of any adverse action, care coordination may re-broker service(s) to another provider at any time the member requests a change in providers.

602.5 Duration of Adverse Action

The adverse action letter will stipulate the time frame within which the provider is required to correct deficiencies. The DCH shall determine the period of adverse action.

NOTE:
The Division of Aging Services/CCSP may conduct an unannounced site visit prior to removal of the adverse action to determine whether the provider has achieved compliance. Failure to achieve compliance by the end of the adverse action period will result in a recommendation to continue the adverse action and/or impose additional adverse action.

602.6 Provider Notification of Adverse Action and Appeal Rights

The DCH will send to the provider a Notice of Adverse Action in accordance with Part I, Chapters 400 and 500 of Policies and Procedures. The notice will include:

A. Reason for imposing the adverse action
The effective date and duration of the proposed adverse action(s) will be determined by DCH. The provider may appeal the action taken by DCH, but appealing the action will not stay the action appealed.

B. The address to which requested information is to be sent and the name of a DCH contact person to call for clarification regarding the notice.

C. The actions and time frame necessary to oppose/appeal the adverse action. If the provider fails to request an Administrative Review or fails to submit the requested information within the time frame specified in the Notice of Adverse Action, the adverse action becomes final and no further administrative or judicial review will be available. If the provider fails to respond to the notice or to correct the deficiencies, the DCH will make a determination on the adverse action, including re-brokering of services with another provider and termination of the provider’s enrollment in the CCSP.

NOTE:
CCSP providers under adverse action are subject to the provisions of Part I, Policies and Procedures For Medicaid/Peachcare for Kids, Georgia Department of Community Health, Division of Medical Assistance, Chapter 400 – Adverse Action, and Chapter 500—Appeals.

603. Admissions

A. Each provider must maintain written policies, procedures and criteria for accepting members referred by the care coordinator. The policies, procedures and criteria apply uniformly to all CCSP referrals. (See Appendix C of the CCSP General Manual).

NOTE: The member must be informed in writing in advance of running any credit checks. Rev 10/14

B. Admissions policies, procedures and criteria may not discriminate or permit discrimination against any person or group of persons on the grounds of age, race, sex, color, religion, national origin, or handicap, in accordance with Title VI of the Civil Rights Act of 1964, as amended, and Section 504 of the Rehabilitation Act of 1973.

C. The Federal Omnibus Budget Reconciliation Act of 1990 includes provisions known as the Patient Self-Determination Act. The Act requires providers of personal care services who receive reimbursement under Medicare and/or Medicaid to inform members of their right to execute Advance Directives for health care (see Appendix D of the CCSP General Manual). Under the Patient Self-Determination Act, a provider may not discriminate against a member who has or who has not executed an Advance Directive.
Home Delivered Meals Services and Emergency Response System providers are exempt from advance directives requirements.

Providers rendering personal care services (Adult Day Health, Personal Support Services, Home Delivered Services, Alternative Living Services, Respite Care, and Skilled Nursing Services) must:

- Comply with all requirements of law respecting Advance Directives.
- Provide written information to members regarding their rights under law to make decisions concerning their medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate Advance Directives.
- Document in the member's clinical record whether an Advance Directive has been executed.
- Maintain in the provider agency file a copy of any executed Advance Directives.
- Provide education for staff on member information concerning Advance Directives.
- Never condition the provision of care or otherwise discriminate against a member who has or has not executed an Advance Directive.

604. Member Assurances

604.1 CCSP Member Rights and Responsibilities

A. Refer to Sections 601.1 - O of the CCSP General Manual. Providers must acknowledge that members have rights and responsibilities regarding participation in the CCSP. At the time of admission the provider reviews member rights and responsibilities with the member and/or member’s representative. After the member reads and signs a copy of the member's rights and responsibilities, the provider gives a copy of the rights and responsibilities to the member and the member’s representative if applicable. The provider places a copy in the member's record.

Member rights recognized by the provider include:

1. The right of access to accurate and easy-to-understand information
2. The right to be treated with respect and to maintain one's dignity and individuality
3. The right to voice grievances and complaints regarding treatment or care that is furnished or not furnished, without fear of retaliation, discrimination, coercion, or reprisal

4. The right to a choice of approved service provider(s)

5. The right to accept or refuse services

6. The right to be informed of and participate in preparing the care plan and any changes in the plan

7. The right to be advised in advance of the provider(s) who will furnish care and the frequency and duration of visits ordered

8. The right to confidential treatment of all information, including information in the member record

9. The right to receive services in accordance with the current care plan

10. The right to be informed of the name, business telephone number and business address of the person supervising the services and how to contact that person

11. The right to have property and residence treated with respect

12. The right to be fully and promptly informed of any cost share liability and the consequences if any cost share is not paid

13. The right to review member's records on request

14. The right to receive adequate and appropriate care and services without discrimination.

15. The right to be free from mental, verbal, sexual and physical abuse, neglect, exploitation, isolation, corporal or unusual punishment, including interference with daily functions of living

16. The right to be free from chemical or physical restraints

**NOTE:**
Providers must be aware of additional member rights and responsibilities required under specific program licensure and must include signed copies of these rights and responsibilities in the member’s record.
B. **Member responsibilities** recognized by the provider include:

1. The responsibility to notify service provider(s) of any changes in care needs

2. The responsibility to treat provider staff in a courteous and respectful manner, as well as cooperate with and respect the rights of the caregivers providing care

3. The responsibility to be as accurate as possible when providing information on health history and personal care needs

4. The responsibility to participate actively in decisions regarding individual health care and service/care plan

5. The responsibility to comply with agreed-upon care plans

6. The responsibility to notify the member's physician, service provider(s), and/or caregiver of any change in one's condition

7. The responsibility to maintain a safe home environment or to inform provider(s) of the presence of any safety hazard in the home

8. The responsibility to be available to provider staff at times services are scheduled to be rendered

9. The responsibility to pay any cost share liability, if applicable

605. **Provider's Evaluation of Member's Needs**

605.1 **Level of Care**

A. Medical services rendered to a member will be ordered by a physician or nurse practitioner on the Level of Care and Placement Instrument. See Appendix E of the CCSP General Manual.

B. A CCSP member must meet the level of care criteria for intermediate nursing home placement. **The Georgia Medical Care Foundation (GMCF) must validate the member’s level of care (LOC) and assign a length of stay (LOS) not to exceed a maximum of 365 days. The member’s physician signs the Form 5588 (CCSP Level of Care Placement Instrument) to attest to the member’s need for a nursing home LOC, after which the CCSP care coordinator RN signs the 5588 to certify the LOC. CCSP services may not begin under the LOS indicated on the Form 5588 until the RN signs the form to certify the LOC.** (Rev. 7/2015)
C. Providers may render CCSP services only to members with a current level of care. Each CCSP member is given an approved Level of Care (LOC) certification for program participation. A LOC certification is approved for no more than a 365 day length of stay. (Rev 1/2015)

D. If a member needs a change in service within 60 days from the beginning date of the LOS, the care coordinator will document and date the added services on the Comprehensive Care Plan and provide a copy to the member’s physician and the service provider(s). No face to face visit or physician letter is required in this situation unless the client is returning to the community from a nursing/rehabilitation facility. See Appendix G of the CCSP General Manual. (Rev 7/2015)

E. If a member with a current LOS under an LOC experiences a change in condition or change in status that requires the addition of new services and/or a change in the level of services, and the change occurs more than 60 days after the beginning date of the LOS, a new LOC assessment (reassessment) is not required. However, approval of the new comprehensive care plan by the member’s physician is required. The CCSP nurse care coordinator must make a home visit to assess the member’s condition and service needs. Changes must be documented on the comprehensive care plan, and the comprehensive care plan must be submitted to the member’s physician by way of the Physician Change in Services Letter (Appendix EE) to request his/her approval of the new plan of care. Copies of the Appendix EE with the physician’s signature and the updated comprehensive care plan must be sent to the provider for the member’s file. The following are examples of changes or new services for which physician approval is required:

*The new service to be added is a skilled service.

*The member needs a change in their level of Adult Day Health (ADH) services.

*The change is service is from one category to another, such as from personal support services (PSS) to alternative living services (ALS).

*A change in service or new service is required for a member after their discharge from a facility that requires a LOC on a DMA-6, such as a nursing or rehabilitation facility.

*A member transfers from one planning and service area to another and requires new services. (Rev. 7/2015)

F. ADH therapies, HDS and SNS (skilled services) additions require physicians orders before specific medical procedures can be
provided. Orders for therapy services must include specific procedure and modalities used frequency and duration of services. (Rev. 7/2015)

G. The care coordinator may add Home Delivered Meals, Out of Home Respite Care, and Medical Social Services to the Comprehensive Care Plan at any time without completing a reassessment. (Rev 4/2015)

H. A member must meet all CCSP eligibility criteria to participate in the program.

**EXCEPTION:** If a member continues to receive services while an appeal of a Level of Care termination is in process, and the LOC expires before the hearing decision is known, the RN does not complete a LOC re-determination. Services may continue to such a member even though there is no current LOC.

605.2 Provider's Initial Evaluation of the Member

Individuals participating in the CCSP are at risk for nursing facility placement and thus require timely evaluation and service delivery.

A. **Contacting the Provider Agency** - Prior to sending a referral packet, care coordinators will telephone provider agencies. Upon receipt of the telephone call, the provider agency must contact the care coordinator within 24 hours if the provider can conduct a face-to-face evaluation in the member's primary place of residence within three business days. If the member is unavailable for evaluation within three business days, the provider will notify the care coordinator. If the member's needs warrant, care coordinators may request the provider to evaluate the member within a shorter time frame.

Rev. 04/09

Rev 07/09

B. **Face-to-Face Evaluation** - A provider agency must conduct a face-to-face evaluation of the member in the member's primary place of residence within **three** business days of receiving the referral from the care coordinator. Within 3 business days of the face-to-face evaluation, the provider will use the CCNF to notify the care coordinator of the decision to accept or refuse the referral. If the provider accepts the referral, the provider indicates on the CCNF the date that services will begin. If the member is hospitalized, institutionalized, or the home environment is not conducive for evaluation purposes, the provider must evaluate the member in a mutually-agreed-upon setting. Services are to begin within 48 hours, if possible, after the provider evaluates the member. If services are to be provided in the member's residence, the provider also must assess the home to determine if it is an appropriate and safe environment for service delivery. The Adult Day Health Provider may elect to evaluate the client in the Adult Day Health setting or the member’s
primary place of residence, depending on the mutually agreed needs of the member. (Rev. 4/10)

C. Evaluating a Member who is Transitioning to the Community under the Money Follow the Person (MFP) Program - When a provider receives a referral to provide services for a member who is preparing to be discharged from a nursing home to the community under the MFP program, the provider should conduct the face-to-face evaluation in the nursing home prior to discharge, as soon as possible after the referral is received. This is done so that services can begin on the first day the member returns home, as authorized by the CCSP care coordinator. A re-evaluation of the member’s needs can be conducted when services have started after the member is settled in the community, following the guidelines in Section 605.3 of this manual. (Rev. 01/2013)

D. Additional Provider Information - If the provider accepts the member for service, the provider will gather any information, other than that already contained in the referral packet, necessary to complete the member's data file in accordance with the provider's requirements.

Care coordination will forward a referral packet to the provider agency within 24 hours of brokering services.

E. Care Plan Changes - If applicable, the provider must contact the care coordinator to obtain prior approval of any desired changes in amount, duration, and scope of services in the comprehensive care plan. The provider must render services to individuals according to the comprehensive care plan. If the provider determines that the services outlined in the comprehensive care plan are not appropriate for the member, the provider notifies the care coordinator immediately. The care coordinator makes a decision after discussions with the provider.

F. Notifying Care Coordinator - Within three business days from the date the provider evaluates the member, the provider must send to the care coordinator a Community Care Notification Form (CCNF-See Appendix I of the CCSP General Manual) to advise the beginning date of service. The provider agency's failure to initiate service as agreed on the CCNF may result in the care coordinator’s rebrokering the service with another provider and recommending adverse action against the provider agency.

G. Member Inappropriate for Services or Declines - If, after the face-to-face evaluation, a provider determines that the member is inappropriate for service, or if for any reason a member declines services from the provider, the provider must immediately telephone the care coordinator during
regularly scheduled office hours and/or within 24 hours. The provider must return the referral packet with the Community Care Notification Form (CCNF) to the care coordinator within three business days from the date the provider determines that the member is inappropriate or the member declines services.

H. Accepting the Referral and Initiating Services - Services are required to begin within 48 hours of the provider's face-to-face evaluation of the member or at the next appropriate day as dictated by the frequency order unless extenuating circumstances delay the start of services. Within three business days of the initial evaluation visit, the provider must send to the care coordinator a Community Care Notification Form (CCNF) indicating the start date of services and documenting the reason(s) for any delay in starting services.

Care coordinators are required to follow up with providers who do not begin services within 48 hours of the face-to-face evaluation unless the stated reason for not starting services is justified as indicated above.

NOTE: The Community Care Notification Form (CCNF) and the provider referral packet may be submitted electronically using encryption or by means of a secure Web site.  

605.3 Provider's Reevaluation of the Member - After Service Initiation

The provider agency engages a Registered Nurse to conduct initial evaluations and periodic re-evaluations of the member’s medical needs during each supervisory visit or more frequently if the member's condition warrants. (Refer to service-specific manuals for frequency of supervisory visits). During the reevaluation the provider RN:

- Reviews the member's problems, approaches to those problems, and identifies responses to the approaches
- Reviews and completes needed updates to the member's care plan
- Communicates problem approaches, updates to care plans and any other pertinent information to appropriate staff caring for a member
- Communicates recommendations for changes in the member’s total care and sends the CCNF to the care coordinator.

NOTE:
A provider must secure care coordinator approval prior to changing services. Within 3 business days after receiving verbal approval from the care coordinator, the provider must follow up by sending to the care coordinator a completed CCNF reflecting the agreed upon change(s) in service.
606. **Member Services**

606.1 **Care Coordinator**

The care coordinator assumes care management responsibilities including member assessment and development of the comprehensive care plan. The care coordinator's basic roles and responsibilities are to:

A. Investigate and refer to appropriate community resources

B. Develop the comprehensive care plan in consultation with the member and service providers

C. Identify desired member outcomes and services needed to restore or preserve member health and safety

D. Serve as a member of a comprehensive care team dedicated to effective delivery of services

E. Certify member’s level of care (LOC)

F. Initiate a discharge plan at initial assessment and coordinate discharge of member

G. Implement the comprehensive care plan by recommending and coordinating the delivery of home and community-based services (HCBS)

H. Broker each CCSP service as an individual service

I. Monitor and evaluate service delivery to members to assure that services are rendered as ordered and provided in a timely and cost effective manner

J. Determine if services are appropriate and effective, monitor changes in member’s health and review the comprehensive care plan at least every 90 days (Rev. 4/2014)

K. Document case activities and service information

L. Coordinate case conferences, as appropriate, with providers and member/member’s representative

M. Communicate with all agencies providing direct services to the member and resolve problems relating to coordination of services

N. Monitor frequency and amount of service in order to ensure that costs are within established limits
O. Initiate the Service Authorization Form (SAF) and forward copies to provider(s). *The SAF is created from the Service Order and reflects the number of days in the month. SAFs are generated initially and when there is a change in services. A copy of the initial SAF and any revised SAFs will be forwarded to the provider(s). Rev 10/14*

P. Make referrals to Protective Services and other non-CCSP services as appropriate

Q. Arrange for emergency services

R. Schedule and complete an annual level of care (LOC) reassessment within 60 days of the expiration of the current length of stay (LOS)

S. Arrange and complete a face to face nursing visit with the member when the member experiences a change in condition

T. Coordinate transfer to other services when the member needs changes or other services (discharge or transfer to a hospital, nursing home, or other community-based care).

U. If the member requests, assist the member with request for a hearing to appeal an adverse action affecting the member’s level of services. *(R through U revised 7/2015)*

606.2 **Member Care**

B. To assure that their efforts effectively compliment one another and support the goals and objectives outlined in both the comprehensive care plan and the Member’s Care Plan, there must be ongoing interaction among provider, care coordinator, and member/member’s representative. The member's clinical record and provider's notes from case conferences must reflect adequate communication, reporting and effective coordination of services.

C. When a provider communicates with the member’s physician, including telephone contacts and medical orders, the provider must adequately document the information in the member’s clinical record

606.3 **Change of Member’s Residence**

A. If the member changes place of residence but remains within the provider's service area, the provider must remind the member to notify the Social Security Administration of the address change. The provider will use the CCNF to notify the care coordinator of the address change within three business days of learning of it.
B. If the member moves to another planning and service area in which the current provider is approved to render CCSP services, the provider must use the CCNF to notify the current care coordinator, who transfers the care coordination file to the new care coordinator.

C. If the member moves to another planning and service area in which the current provider is not an approved CCSP provider, the provider will use the CCNF to notify the care coordinator. In addition, the provider must send a complete copy or summary of the member’s clinical record to the current care coordinator to include in the care coordination case record. Before placing the record in the inactive file, the provider will check to determine if the original clinical record includes the member’s new address and the effective date of transfer. Upon receipt of the CCNF and clinical record information, the current care coordinator will transfer the copy of the member’s clinical record and the original care coordination case record to the new planning and service area.

606.4 Clinical Records

A. A provider must maintain clinical records on all members in accordance with accepted professional standards and practices. To facilitate retrieving and compiling information, the provider must assure that clinical records are accurately documented, readily accessible, and organized.

A provider must protect the confidentiality of member information and safeguard against loss, destruction, or unauthorized use. The provider must have written procedures known to all staff and sub-contractor which govern the use and removal of records and the conditions for release of information.

B. A provider must protect the confidentiality of member information and safeguard against loss, destruction, or unauthorized use. The provider must have written procedures known to all staff and sub-contractor which govern the use and removal of records and the conditions for release of information.

C. The clinical record for each member must contain sufficient information to identify the member clearly, to justify the comprehensive care plan and treatment, and to document accurately the results of treatment. All provider clinical records must include the following:

1. Referral packet forwarded by the care coordinator. The referral packet includes:

   a. Copy of Level of care and Placement Instrument, signed and dated by the physician
b. MDS-HC V9 and Comprehensive Care Plan which includes:

i. Client Detail

ii. Assessment Questions short

iii. Determination of Need

iv. Care Plan, including CAPs, Service Order and Task Lists (Rev 1/2015)

v. Copy of signed Authorization for Release of Information and Informed Consent (Signature page)

vi. If client is MAO or PMAO, copy of the completed Potential CCSP MAO Financial Worksheet, which contains client signed Statement of Intent: Cost Responsibility

c. Any other relevant information, including:

i. Psychological and Psychiatric evaluations

ii. Information about client that the provider needs before completing an evaluation/assessment

iii. Copy of the DHS Authorization for Release of Information, if applicable (See Appendix L of the CCSP General Manual)

**NOTE**: If the level of care is not consistent with the comprehensive care plan, an addendum must be noted on the service order, and a copy of the Physician Change in Services Letter (Appendix EE) must be attached. (Rev. 7/2015)

2. results of the provider's initial evaluation of the member and the provider's acceptance or reason for non-acceptance of the individual into service

3. notes from case conferences indicating results of all provider’s reevaluation of the member

4. current and previously signed and dated Member Care Plans (see Appendix K of the CCSP General Manual) by the provider RN during each supervisory visit.

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EXCEPTION: ERS and HDM services do not require member care plans.

5. documentation of supervisory visits and clinical notes signed and dated by the person(s) rendering services, and incorporated in the medical record

6. medication, dietary, treatment, and activity orders when ordered on a specific member

7. documentation of all communication (written and verbal) between the provider RN and the member's physician

8. documentation of all communication (written or verbal) between provider staff, care coordinator, and other service providers or persons involved in the member's care

9. instructions for dealing with medical emergencies of the individual member (in accordance with advance directives, if appropriate) and documented on the emergency information plan. (See Appendix U)

10. documentation of member's service on a member service record form

EXCEPTION: ERS providers are not required to complete a service record form.

11. if the service is provided in the member's home, clear and specific directions to the member's home from the provider agency

12. Advance Directives, if applicable (See Appendix D of the CCSP General Manual)

13. discharge plan and, if appropriate, discharge notice

14. copies of the comprehensive care plan, updated every 90 calendar days (rev 10/1/13)

15. signed copy of member's rights and responsibilities (See Section 604.1 of the CCSP General Manual)

16. admission or service agreement, if applicable. Such admission or service agreements must be typed in sufficiently large, clear, and commonly used type face to be easily read, and in language which is appropriate for the educational levels and cultural backgrounds of the members.

NOTE:
Home Delivered Services providers refer to the Home Delivered Services Manual for clinical record requirements for CCSP members.

606.5 **Authorization for Release of Information**

- A provider is prohibited from disclosing information contained in member records to any person other than authorized representatives of DCH, DHS, or providers without the expressed written consent of the member.

- A provider must use only the official Georgia Department of Human Services form to authorize release of member information (Appendix L of the CCSP General Manual). This form authorizes the sharing of member information among DCH, DHS, and providers. The care coordinator will include a copy of the signed form, if applicable, in the initial referral package sent to each provider.

- To share member information with persons other than those specified above, the provider must obtain additional written authorization from the member prior to releasing any such information.

606.6 **Discharge Planning**

A. Providers and care coordinators must maintain a coordinated program of discharge planning to ensure that each member has a planned program of continuing care which meets the member's post-discharge needs.

B. The care coordinator must begin developing the discharge plan during the initial assessment. Thereafter, the provider's RN is responsible for coordinating discharge planning in consultation with the member, the member's care coordinator, the member's physician, other provider staff, other involved service agencies, and other local resources available to assist in the development and implementation of the individual member's discharge plan.

C. Member Care Plans must clearly reflect discharge planning efforts.

D. The care coordinator and providers must consider the following factors in discharge planning:

   - problem identification
   - anticipated progress
   - evaluation of progress to date
   - target date for discharge
   - identification of alternative resources for care after discharge.
E. Upon discharge, the provider will furnish an appropriate discharge summary to those responsible for the member's post-discharge care. The discharge summary must include information concerning:

- information on current diagnoses
- an evaluation of rehabilitation potential
- description of course of prior treatment
- copy of the most recent Member Care Plan
- other pertinent information needed by post-discharge caregiver

606.7 **Discharge of Members**

If a care coordinator or UR analyst recommends a reduction or termination of service(s), the member may choose to appeal the adverse action decision and request continuation of services during the appeal process. For services to continue, the member must appeal within 10 days of the adverse action notice. If the member does not appeal, discharge from service occurs 10 days from the member's receipt of the adverse action notice.

**NOTE:**
Payment to the provider for delivered services continues during the appeal process.

A. Discharge occurs when any of the following occurs:

1. The care coordinator determines that the member is no longer appropriate or eligible for services under the CCSP.

2. DMA's Utilization Review (UR) staff recommends in writing that a member be discharged from service. (See Appendix M of the CCSP General Manual.)

3. The enrolled member has received no CCSP services for 60 consecutive calendar days. If a CCSP member is hospitalized or receiving Medicare Home Health Services, the member is considered to have received a reimbursable waivered service.

4. An MAO member fails to pay cost share in accordance with the provider-member agreement.

5. The member/member's representative consistently refuses service(s).
6. The member’s physician orders the member’s discharge from CCSP.

7. The member enters a nursing facility. The provider must send the notice of discharge immediately upon the member's placement in a nursing facility. EXCEPTION: ERS services may continue for up to 2 months (62 days) if the member is expected to return home.

8. The member enters another home and community based waiver, such as SOURCE, ICWP or NOW/COMP. Send notice of discharge based on the discharge date negotiated with the new waiver case manager by the CCSP care coordinator, waiving the 30 day advance notice requirement. Rev. 01/2013

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

10. Member/member’s representative or care coordinator requests immediate termination of services. The provider must document in the member’s record the member’s request for a change in provider.

11. Member moves out of the planning and service area to another area not served by the provider.

12. Member dies.

13. Provider can no longer provide services ordered on the comprehensive care plan.

B. When a CCSP member is discharged from the program, the provider must deliver service through the effective date of discharge EXCEPT when any one of the following occurs:

1. Member enters a nursing facility

2. **member enters another HCBS waiver program** Rev 01/2013

3. Member exhibits and/or allows illegal behavior in the home

4. Member/member’s representative or care coordinator requests immediate termination of services

5. Member moves out of planning and service area

6. Member dies.

C. In all discharges, the provider agency must:
a. Send a written notice to the member/member’s representative/legal guardian and the care coordinator thirty calendar days prior to actual discharge date.

**EXCEPTION:** When UR or the care coordinator recommends discharge or the member dies.

b. Include in the written discharge notice the **effective date** of discharge and the **reason for discharge**.

c. Send the discharge CCNF to the care coordinator.

d. Notify the member’s physician

**EXCEPTION:** ERS and HDM providers send only a CCNF to the care coordinator.

e. Document the reason for discharge in the member’s record.

606.8 **Change in Level of Service**

A. A **decrease** in the member's level of services is appropriate when the following occurs:

1. The care coordinator, in consultation with the provider determines that the current level of service is no longer appropriate, or

2. DMA's Utilization Review (UR) recommends a reduction in the level of services (see Appendix M of the CCSP General Manual).

B. An **increase** in the member's level of services is appropriate when the care coordinator determines that the current level of service is no longer sufficient. Utilization Review Analysts may recommend an increase in services.

C. When the provider determines that a member needs an increase in level of services, the provider confers with the care coordinator to secure
approval prior to increasing the level of services. Within 3 business days after receiving verbal approval from the care coordinator, the provider must follow up by sending to the care coordinator a completed CCNF reflecting the agreed upon increase in level of services. If appropriate, the care coordinator then updates the comprehensive care plan and generates a revised Service Authorization Form (SAF).

606.9 **Medications - Monitoring and Administration**

A. **Monitoring Member Medications**

The provider's supervising RN must monitor all prescription and over-the-counter medications taken by CCSP members. Member records must contain the following information related to medication:

1. A current list of prescription and over-the-counter medications taken by the member, including the name of each medication, dosage, route, and frequency taken.

2. All drug side effects observed by or reported to the provider supervising RN by the member or other provider staff.

3. Documentation that the provider reports to the physician in a timely manner any problems identified with medications. The provider must record the physician's order to change any medication.

B. **Administration of Medications**

Only the attending physician may prescribe therapeutic or preventive medications. Only licensed nursing staff may administer medication, and only on direct orders from the physician.

**EXCEPTION:** Unlicensed proxy caregivers are allowed to perform certain health maintenance activities as long as they have the member’s full written informed consent and are trained and certified as specified in Chapter 111-8-100 of the Rules of the Georgia Department of Community Health, Healthcare Facility Regulation Division, entitled “Rules and Regulations for Proxy Caregivers used in Licensed Healthcare Facilities.”

**Rev. 10/13**

If a licensed nursing staff member or a proxy caregiver administers medications, member records must include, in addition to information specified in 606.9A of the CCSP General Manual, the following documentation:

(1) Physician's authorization for the administration of any medication. The physician may renew this authorization on the Level of Care and Placement Instrument at the time of the
member's level of care re-determination or through written physician orders at any other time.

(2) When obtaining a physician's verbal authorization, documentation of the consultation, and written follow up within 30 days to confirm the authorization.

(3) The name, dosage, route, and frequency of any medications administered by the licensed nursing staff member or proxy caregiver. The person administering the medication must sign and date all notations.

NOTE:
In the clinical record, the provider must record physician’s orders for all prescribed medications and treatments directly related to services being delivered. Over-the-counter medications, supplements, and herbs are reported to the member’s pharmacist and/or physician by the supervising RN for determination of any possible interaction with the member’s prescription/medications. The label of a prescription medication constitutes the pharmacist’s transcription of documentation of the order. Such medications should be noted in the clinical record and listed on the re-certification plan of care (HCFA-4850).

C. Assistance With Self-Administered Medications

An aide may assist the member with physician-prescribed medications that are to be self-administered. Assistance is limited to the following:

1. Reminding the member to take the medicine

2. Reading to the member the correct dosage and frequency indicated on the container label

3. Assisting the member with pouring or taking the medication

The aide will report to the RN supervisor any changes in the member’s condition, including those which may be related to medications.

The provider agency, member and/or supervising registered nurse must immediately communicate any concerns regarding the member’s medications, including the number or frequency in use, to the member’s physician. The supervising registered nurse must report these concerns to the care coordinator within 24 hours. Within three business days of verbally notifying the care coordinator, the provider must send a completed Community Care Notification Form to the care coordinator.

606.10 Durable Medical Equipment (DME)
A. For procedures relating to purchase, rental, repair, maintenance, and delivery of equipment and appliances, refer to the DMA Policies and Procedure Manual for Durable Medical Equipment.

B. Call the Provider Enrollment Unit at 1-800-766-4456 (toll-free) to request the DME service manual.

C. The provider must either assure provision of DME or make a referral to the care coordinator, as follows:

If the DME item is directly related to the service being provided under the CCSP, and is reimbursable under the Medicaid program, the CCSP provider assists the member in obtaining the item through a vendor enrolled with the Division of Medical Assistance. If requested by the DME vendor, the provider assists the member in obtaining a prescription or certificate of Medical Necessity from the physician.

If the needed equipment is not directly related to the service being provided, the provider agency will alert the care coordinator, who will assist the member in obtaining the item(s) through a Medicare or Medicaid approved vendor.

D. Within three business days of identifying the member's need for DME, the CCSP provider must send to the care coordinator a completed Community Care Notification Form (CCNF).

606.11 Non-Emergency Transportation Services (NET)

For more detailed information, contact the NET broker serving the member's location. Refer to Appendix T of the CCSP General Manual for NET Brokers.

**NOTE:** The Elderly and Disabled Waiver 1915 (c) does not include transportation in the rate for personal support or extended personal support services. NET is available to all Medicaid participants under the State Plan to provide transportation to medical appointments and for waiver services such as adult day health. A provider who allows an aide to make use of a member’s or aide’s car for transport needs to be sure the member’s or aide’s auto insurance assumes liability in case of an accident. Consider having the member or their family sign an agreement that discusses the assumption of liability in case of an accident. The provider should also carry adequate liability and worker’s comp insurance to cover any accidents. Any such transportation activities are at the risk of those who engage in them. Providers should consult their legal team to determine the extent of liability to which the agency may be exposed through such transportation activities, particularly if an aide assumes that this is part of their normal duties. (Rev 4/2015)
606.12 **Emergency Information**

A. The provider must maintain written emergency information on each member. The emergency information must be easily accessible in the member’s record and, at a minimum, includes:

1. name and telephone number of the member’s attending physician
2. member's hospital preference
3. names and phone numbers of member's representative and other emergency contacts
4. Known medication/pertinent medical information, including allergies

B. Provider staff members who deliver services must receive initial and ongoing training in dealing with medical emergencies. Provider staff must maintain current certification and/or training in basic first aid and cardiopulmonary resuscitation (CPR). Certification must be obtained through an approved, certified instructor.

**EXCEPTION**: ERS and HDM providers.

C. The clinical record must contain the member’s written authorization for staff to seek emergency treatment, including transportation for treatment. The provider must keep emergency information current by reviewing and updating it at least yearly and as needed. (See Appendix U of the CCSP General Manual).

606.13 **Fees for Services**

A. CCSP Members

1. A provider may not solicit or accept any contributions or gratuities from members or others for CCSP services rendered.

2. The care coordinator uses the Service Authorization Form (SAF) to indicate the amount of the cost share for each MAO member and the provider assigned to collect it.

3. Division of Aging Services determines the approved room and board rate for CCSP Alternative Living Services’ members.

**NOTE**: Members receiving Supplemental Security Income (SSI) are not required to pay toward the cost of their CCSP services.
4. Providers may not charge CCSP members interest rates or late fees for CCSP services.

B. Private Pay Members

If an agency's private pay fee schedule is less than the approved CCSP reimbursement rate, the provider must submit the schedule to the DMA for review. The schedule must include justification for charging a lower fee to private-pay members.

606.14 Food and Nutrition

Providers must deliver meals that meet the nutritional standards according to the specific program requirements for each service type (see Appendix O of the CCSP General Manual).

606.15 Service Delivery Hours

Providers rendering CCSP services in the member's home must use flexible scheduling to meet the individual member's needs and preferences for service. The provider's RN must be available to provider staff during hours that they deliver services. (See Section 601.1 M of the CCSP General Manual)

606.16 Physician Certification

The care coordinator orders services for members.

A licensed physician, nurse practitioner or physician assistant must approve the member services listed on the Form 5588 (CCSP Level of Care and Placement Instrument) except in the following situations:

- The member experiences a change in condition that requires a new service, additional services (such as additional personal support service hours) or a change in the level of Adult Day Health services and the change occurs more than 60 days after the beginning date of the member’s current length of stay (LOS) under a nursing home level of care (LOC). The physician’s approval for new services or a change in the level of ADH services must be communicated through the physician’s signature on the Physician Change in Services Letter (Appendix EE).

- The care coordinator adds other CCSP services within 60 days of the beginning date of the current LOS under a nursing home LOC. (Rev. 7/2015)

Skilled and therapy service providers (ADH, SNS and HDS) require medical orders for specific medical procedures provided by agency staff. Physician
orders for therapy services must include the specific procedures and modalities used and the amount, frequency, and duration.

**EXCEPTION:** Home Delivered Service providers must follow appropriate regulations regarding the Medical Plan of Treatment. Refer to the Department of Community Health’s Policies and Procedures for Home Health Services.

**NOTE:** The care coordinator may add HDM, RC and Medical Social Services at any time

606.17 **Supervision of Services by a Registered Nurse (RN)**

Registered Nurse (RN) supervision is the provision of medical oversight to ensure that the provider serves the member effectively and safely in the community. Medical oversight includes assessing and monitoring the member's condition and implementing/arranging interventions to prevent or delay unnecessary and more costly institutional placement. A RN must supervise all CCSP services.

The registered nurse may assign certain tasks to unlicensed assistive personnel. The registered nurse will utilize the “RN Assignment Decision Tree,” generated by the Georgia Board of Nursing, to assist the registered nurse in making appropriate decisions regarding whether to assign a task to an unlicensed person. The RN Assignment Decision Tree assists the registered nurse in evaluating the client care tasks on an individual client basis; it guides the nurse in assigning only those tasks that can be safely performed by trained unlicensed assistive personnel. (Refer to Appendix Z of the CCSP General Manual).

**EXCEPTION:** HDM and ERS providers

NOTE:
Refer to the specific service manual for additional staffing and supervision requirements, exceptions, or substitutions. Providers not following the required supervision policies will face adverse action, up to and including possible termination from the CCSP.

A. The major tasks of the Registered Nurse include, but are not limited to:

1. Assessing and evaluating the member's needs, current status, environment, and changes during each supervisory visit or more often if indicated by member’s condition

2. Reviewing the Level of Care and Placement Instrument

3. Conducting supervisory visits and re-evaluations of member care at the required frequency (refer to service-specific manual) or more often if medically necessary
NOTE:
Nursing staff are prohibited from administering medications to members or providing any other member care while conducting supervisory visits.

4. Developing, coordinating, and revising member care plan. Communicating all revisions to appropriate staff.

5. Preparing progress/clinical notes, reviewing progress note entries of all staff, reviewing and co-signing documentation of all LPN supervisory visits and instructing staff on charting protocol. The RN must indicate his/her review of notes and LPN supervisory visits, as well as the follow-up and resolution of problems, by signing and dating the documentation of all of the above. (Rev. 12/10)

6. Conducting and maintaining ongoing communication with other service providers, the physician, care coordinator, and other relevant parties of changes in the member's medical condition or any change in member status that requires follow-up and/or additional services. The RN/provider must obtain the care coordinator's prior approval for changes in the member's service except in emergency cases.

7. Counseling and educating the member/representative, caregiver(s), and staff in meeting the member's medical and related needs.

8. Other duties assigned by the provider agency such as quality assurance activities and/or planning, scheduling and conducting in-service training sessions, etc.

9. In addition to the tasks listed above, the Home Delivered Service RN reviews the Medical Plan of Treatment (MPOT) and obtains the physician's dated signature a minimum of every sixty-two calendar days.

B. Nursing supervision of CCSP services must comply with the following guidelines:

1. The RN supervisor must document, sign and date supervisory visits/notes/contacts and label them as such. Names and titles must be legible. Staff may use initials if their signatures are on file at the provider agency. The supervisory RN signature must be an original, not a rubber stamp.
EXCEPTION: An electronic signature and computer-generated signature, requiring the supervisory RNs' access codes to generate, are permitted.

2. The provider RN supervisor must conduct a face-to-face supervisory visit with the member to cover every period of service provided. If the member is not present, the visit is not considered a supervisory visit.

C. Documentation of each RN or LPN supervisory visit must include the following:

1. An evaluation of the member's health status and needs, noting changes in medical condition, medications, etc.
2. An evaluation of the quality of care being rendered, including member's statement of the level of satisfaction with services received
3. Results of the care being rendered
4. Planned interventions and follow-up for any problems identified
5. Any needed revisions to the member's care plan
6. The nurse’s signature and date of the visit (see note below).
7. The date of the previous supervisory visit. (Rev. 4/12)

NOTE: A checklist does not replace narrative documentation, but can be used in addition to support narrative.

NOTE: The RN or LPN who makes the supervisory visit must sign and date the documentation of the visit. If the supervisory visit was made by an LPN, the supervising RN must review and co-sign the documentation of the LPN’s visit within 10 days unless otherwise stated in the provider manual for the particular service. (Rev. 12/10; 10/14).

606.18 Member Care Plan

The Member's Care Plan (see Appendix K of the CCSP General Manual) reflects the provider agency's plan to deliver the services agreed upon by the provider agency, the member/member’s representative and the care coordinator based on the comprehensive care plan.

Individuals who participate in the Community Care Services Program have been determined to be at risk for nursing facility placement. Therefore, after the initial evaluation, the provider RN must review the care plan and revise, sign and date it as part of each supervisory visit, or as often as the member's
condition requires. The provider RN communicates all revisions to the care plan to appropriate staff. The member care plan must be re-written at least once per year.

NOTE:
Home Delivered Meals and Emergency Response Services do not require a member care plan.

A. The written member care plan must identify the following:
   1. specific physical, mental, and social health problems of the member.
   2. specific approaches that will be taken to address the member's health needs/problems
   3. persons or agencies responsible for providing services to the member
   4. instructions for timely discharge or referral, if appropriate
   5. any other appropriate items

B. Guidelines for Preparation of Care Plan
   1. The provider RN initiates member care plans within 72 hours of the provider's initial evaluation of the member. The provider RN maintains current member care plans, including any changes in effective dates of coverage. The provider RN reviews the member care plans during each supervisory visit or more often if required by the member’s condition
   2. The provider RN will develop the member care plan and coordinate care with input from the provider staff involved in the member's care. Provider staff must immediately bring to the attention of the provider RN any concerns about significant changes in the member's status.
   3. Before a provider implements changes in frequency and type of service, the provider must discuss these care plan revisions with the care coordinator. The care coordinator must review and approve changes in services.
   4. The member care plan must indicate approaches necessary to achieve identified goals (e.g., nutrition education, methods of care coordination, etc.).

NOTE:
A copy of the recommended member care plan format is included in Appendix K of the CCSP General Manual. A provider may use a different format as long as it includes all elements listed on the form provided.
606.19 **Progress/Clinical Notes**

A member's clinical record must contain written progress notes, or clinical notes, which reflect the member's progress toward the goals and objectives identified in the member care plan. The RN supervising the member's care will prepare progress notes; however, any staff rendering care to the member may make notations in the clinical record. The notations may be recorded on the service form that reflects the date of service and must describe significant events/reactions/situations and follow-up which affect the member’s care. All entries must be signed and dated at the time of occurrence. **The provider RN must review, sign and date all entries made by non-licensed staff.**

Progress notes must be kept readily available for review by supervising personnel. The provider RN must train non-licensed staff on how, when, and where to keep progress notes. At a minimum, the provider RN must include progress note entries in the supervisory visit documentation, in accordance with the minimum frequency requirements of the specific CCSP service being delivered. (Refer to service-specific manuals).

606.20 **Community Care Notification Form**

A. Service providers and care coordinators are expected to be proactive on behalf of the CCSP member and maintain active dialogue within the care team.

The provider and care coordinator use the Community Care Notification Form (Appendix I of the CCSP General Manual) to maintain an ongoing, documented dialog concerning:

- Beginning date of services
- Reason(s) for delay in starting services
- Acceptance or rejection of member referral following the initial evaluation
- Provider's evaluation that the member is inappropriate for CCSP services
- Member address change
- Changes in member's situation or environment (including social supports)
- Changes in the member's physical or mental condition/status
- Recommendations for changes to the care plan, including changes in services that increase or decrease the total cost of services.
NOTE:
If visit(s) is (are) shortened or omitted due to a member’s absence, the provider may submit a completed CCNF on the last working day of that month.

- Concerns regarding the number and frequency of member's self-administered medications
- Provider identification of member's need for durable medical equipment
- Member hospitalization, discharge, or death
- Problems with cost share collection

If any of the above occurs, the provider must telephone the care coordinator within 24 hours and will submit the completed CCNF to the care coordinator within three business days of the change or action.

The procedure for notification is as follows:

1. Notification Regarding New Members:

   Refer to Section 605.2 of the CCSP General Manual

2. Notification Regarding Changes in Services:

   Service providers must contact the care coordinator either before providing the service or the next business day. The provider must request all changes in service by completing the CCNF and forwarding it to the care coordinator.

   The provider must obtain approval from the care coordinator prior to rendering a new service.

   Within three business days after receiving the CCNF, the care coordinator will initial, date, and return the CCNF to the provider, approving or denying the change in service.

   If changes in the comprehensive care plan are approved, the care coordinator will revise the comprehensive care plan to reflect the changes and forward a copy to the provider(s). The provider RN will revise the member care plan to reflect the changes in the member's care.
Non-Emergency Service - If the provider and/or provider RN determines that the member needs a change in service, the provider must obtain approval from the care coordinator before initiating a change in service. The provider must telephone the care coordinator on the first business day following the determination that a member needs a change in service and must follow up with a completed CCNF within three (3) business days.

Emergency Visit - If the provider and/or provider RN determines an emergency visit is required, the provider must immediately call the care coordinator and follow up with a Community Care Notification Form within three (3) business days. Examples of emergency situations include, but are not limited to:

- loss of caregiver support
- need for urgent care
- need for immediate attention due to compromised safety or health.

Exceeding the Authorized Cost - If a needed change in service (emergency or non-emergency) would cause the cost of care to exceed the amount authorized on the Service Authorization Form (SAF), the provider RN must obtain payment authorization in accordance with Chapter 800 of the CCSP General Manual.

1. Change in Address

a. If a member moves to another address within the same Planning and Service Area, OR moves to another Planning and Service Area in which the current provider is approved to render services

The provider must:

- telephone the care coordinator, within 24 hours of learning about the member's move
- send a completed CCNF to the care coordinator within 3 business days advising of the address change
- transfer member records to the office serving the member’s new address, if applicable

b. Member moves to another Planning and Service Area in which the current provider is not approved for service

The provider must:
o telephone the care coordinator, within 24 hours of learning of the address change

o send a completed CCNF to the care coordinator, within 3 business days

o send a discharge CCNF and a statement summarizing the services provided to the member, the reason for the member’s move, and any special concerns to the care coordinator

B. Hospitalization and Other Changes that Affect the Plan/Delivery of Care

o The provider will send a completed CCNF to the care coordinator, within 3 business days

o The provider will telephone the care coordinator within 24 hours of learning of the hospitalization, emergency room visit or other change in the member’s status (e.g., physical or social health status, informal support system, environmental/community status, etc.).

o The provider sends a completed CCNF to the care coordinator within three business days.

C. Nursing Facility Placement

o The provider will telephone the care coordinator and follow up with a completed CCNF to the care coordinator within three business days of learning that the member has been admitted to a nursing facility.

o If a nursing facility discharges a member who needs CCSP services reinstated, the nurse care coordinator must complete a face to face review of the member, within 48 hours of having received notice of the discharge, to assess the need for services not currently included on Form 5588 (CCSP Level of Care and Placement Instrument). If new services are indicated, the nurse care coordinator must document the new services on the member care plan and submit a request for approval to the member’s physician on the Physician Change in Services Letter (Appendix EE). (Rev. 7/2015)

o Providers who render services to members without a current CCSP Level of Care and Placement Instrument will not receive Medicaid reimbursement.

D. Member’s Death:

Within three business days after the provider learns of a member's death, the provider will use the CCNF to notify the care coordinator. The
information on the CCNF must include the date of death (if known) and the last date of service. Refer to Section 606.7 of the CCSP General Manual.

Potential Medical Assistance Only (PMAO) Members

PMAO members have incomes which exceed the current Supplemental Security Income (SSI) level. PMAO Members, screened by care coordinators and providers to determine their potential eligibility for CCSP Medicaid benefits, may be required to pay toward the cost of their CCSP services (cost share).

A. Brokering PMAO Members - PMAO members, who do not yet possess current Medicaid member numbers, are determined eligible for Medicaid services by the Division of Family and Children Services (DFCS). Care coordinators will broker services for Potentially Medical Assistance Only (PMAO) members with providers. If the member is PMAO:

1. During assessment, the care coordinator must inform the member of the possible requirement to pay a portion of the cost of services (cost share), and must discuss the Medicaid eligibility process with the member/representative.

2. Both the care coordinator and the service provider must reinforce the member's cost share responsibility by clearly informing the member that if cost share is not paid, the member is at risk of losing CCSP services.

3. The care coordinator must include in the referral packet sent to the provider a copy of the PMAO Financial worksheet indicating estimated cost share.

4. Once the care coordinator receives a CCNF verifying that the PMAO member has begun receiving service, the care coordinator must advise the member to apply for Medicaid benefits through the local County DFCS, and will assist the member in arranging transportation to DFCS if necessary.

5. Within two weeks of referring the member to DFCS, the care coordinator must contact the County DFCS to determine the Medicaid application date and/or if the member has been interviewed.

6. The care coordinator must make a good faith effort to ensure that the member is proceeding with the Medicaid eligibility process. If the care coordinator determines that the member is having difficulty with the process, a case conference is scheduled with the member and DFCS to define areas where assistance is needed.
7. Within 45 days of the Medicaid application date, the care coordinator must contact DFCS to ascertain the member's eligibility status. If DFCS has not yet determined the member's Medicaid eligibility, the care coordinator will contact DFCS at least every two weeks until eligibility is established.

B. Accepting a PMAO member - When the provider accepts a referral for a PMAO member, the care coordinator must give the member a written estimate of the cost share amount prior to the delivery of services.

The provider must inform the member in writing that the member is responsible for the total cost of all services rendered if DFCS later determines that the member is ineligible for Medicaid, or if the member fails to proceed with the Medicaid application.

C. Cost Share Collection - The provider must have written policies clearly describing cost share billing/collection and refund policies and procedures. For PMAO members, the provider may either:

1. collect only the estimated cost share from the member. If this method is chosen, services to the member must be delivered before collecting cost share. The provider must bill the member for cost share at least monthly. The provider is not required to wait until the end of the month before collecting cost share, but may collect cost share as service is provided until the provider has collected the entire cost share.

   EXCEPTION: ALS providers may collect cost share at the beginning of the service month.

   or

2. collect the entire cost of service from the member until DFCS establishes Medicaid eligibility

Prior to delivering service, the provider must furnish the member written notice as to which of the above collection methods will be used.

D. Reconciliation of the Member's Account - Within 30 calendar days of receipt of the SAF(s) showing the actual cost share, the provider must return any excess cost share collected, or bill the member for any remaining cost share due the provider. A member determined ineligible for Medicaid is responsible for the entire cost of services delivered.

E. Reimbursement from Medicaid - The provider may not submit claims for Medicaid reimbursement until DFCS assigns the member a Medicaid member number. Within three business days of the receipt of the Community Care Communicator (CCC), Form 5590, from DFCS, the
care coordinator must generate Service Authorization Forms showing the member's Medicaid member number and actual cost share. (Refer to Chapter 700 of the CCSP General Manual).

F. **Member MAO Eligibility** - Once eligibility is established and the actual cost share is determined, the PMAO member becomes MAO eligible.

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<td>In situations where a member’s cost share is reduced after the member has paid, the care coordinator will adjust the SAF to enable the provider to bill Medicaid for the difference. The provider's cost share policy will state if the overpayment shall be credited or refunded.</td>
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**606.22 Medical Assistance Only (MAO) Members**

A Medical Assistance Only (MAO) member is one who receives Medicaid benefits but who receives no cash assistance such as Supplemental Security Income (SSI). MAO members may be required to pay toward the cost of CCSP services (cost share).

A. **Cost Share Collection**

1. The CCSP provider must furnish the member a written statement of the amount of cost share, if any, each month cost share is due.

   The monthly statement will include:
   
   ii. The date of the statement
   iii. The amount due,
   iv. The date payment is due
   v. The statement that, “If the bill is not paid within 30 calendar days, discharge from the agency will be effective the 46th calendar day from the date of this statement”.

2. Providers will bill for cost share at least monthly.

   (See Section 606.13 A2 of the CCSP General Manual).

B. **Members Failing to Pay Cost Shares**

   The provider may discharge a member from service for failure to pay cost share after the provider has given appropriate written notice on the monthly statement (see Section 606.22 A1of the CCSP General Manual).

   The care coordinator and provider will advise members and/or member’s representatives that providers may discharge members who fail to pay cost share.
If the member does not pay cost share by the 31st day, as indicated on the monthly statement, the provider will notify the care coordinator that services will be discontinued on the 46th day from the date of the statement.

Within three business days, the provider will submit a CCNF and a copy of the cost share bill to the care coordinator (see Section 606.13 of the CCSP General Manual).

If the Care Coordinator attempts to broker the service with another provider, the Care Coordinator will inform the potential/subsequent provider of the member’s failure to pay the required cost share to the current provider(s).

Care coordinators will frequently discuss cost share with members but will not engage in collection activities.

Providers who have difficulty collecting cost share will discuss the problem with the care coordinator as soon as it occurs.

607  Staffing

607.1  General

A. Staff Qualifications – The provider must employ a sufficient number of qualified and experienced staff members who are appropriately skilled and available to render services in their approved service areas in accordance with currently accepted standards of medical practice (refer to the service-specific manuals for program requirements related to staffing). Providers are required to screen each potential employee for competency.

Personnel providing CCSP services must:

- be qualified by education, training and/or experience to perform the tasks assigned
- fulfill all training requirements
- undergo criteria-based job performance evaluations of their job performance at least annually, including evaluation by members at least annually.
- be supervised by appropriately credentialed staff who are licensed and accountable for quality service and outcomes
B. **Registered Nurse (RN) Supervision and Credentials** - All CCSP services (except ERS and HDM) require that a licensed RN supervise the services delivered to CCSP members. Refer to the service-specific manuals for information regarding other required licenses.

C. **Licensure** – Providers maintain evidence of current licensure for all staff members in occupations requiring Georgia licenses or permits.

D. **Designated Professional Staff** - A licensed professional, designated to provide professional supervision and oversight, will be available to staff at all times that services are being rendered to members.

E. **Designated Management Staff** - The provider must designate a responsible staff person to act as manager in the administrator/manager’s absence.

F. **NOTE:** All provider staff members responsible for documentation of member records must be identified by name and discipline and include a sample of the staff member’s signature and initials. This legend must be on file with provider agency and available at the agency place of business.

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607.2 **Volunteers**

Providers may use volunteers to provide CCSP services, provided they meet the same qualifications required of paid staff. The provider is responsible for the supervision and performance of any volunteer who provides direct member service for the provider agency.

607.3 **Personnel Policies**

A. The provider must have written personnel policies and procedures.

B. The provider must establish and maintain current personnel records for all staff and volunteers. Each personnel record must include the following, at a minimum:

1. criteria-based job description, signed and dated by the employee
2. criteria-based performance evaluation
3. job application and/or resume
4. proof of current Georgia licensure, if applicable
5. documentation of knowledge of agency’s policies related to Member Protection Assurances
6. documentation of all training completed
7. proof of satisfactory physical examinations and tuberculosis screening, as required
8. signed and dated copy of the code of ethics.
9. evidence of a satisfactory criminal history background check determination

C. Code of Ethics - All providers must have an ethics policy which is signed and dated by all persons under the provider's direction. The ethics policy, at a minimum, must prohibit employees, volunteers or contracted individuals from:

1. using the member's car for personal reasons
2. consuming the member's food or beverage
3. using the member's telephone for personal calls
4. discussing political or religious beliefs, or personal problems with the member
5. accepting gifts or financial gratuities (tips) from the member or member’s representative
6. lending money or other items to the member; borrowing money or other items from the member or member’s representative
7. selling gifts, food, or other items to or for the member
8. purchasing any items for the member unless directed in member care plan
9. bringing other visitors (e.g., children, friends, relatives, pets, etc.) to the member's home
10. smoking in the member's home
11. reporting for duty under the influence of alcoholic beverages or illegal substances
12. sleeping in the member's home
13. remaining in the member's home after services have been rendered
All agreements with contracted personnel including those responsible for their own withholding taxes, must be in writing. Refer to Section 601.1 J of the CCSP General Manual.

A provider may delegate authority, but responsibility for performance of individuals under contract may not be delegated to another agency or organization.

607.5 **Staff Development and Training**

A. The CCSP provider is responsible for developing and implementing a continuing education program for all employees/staff members, subcontractors and volunteers of the agency. Continuing education will consist of orientation for all new employees/staff, subcontractor’s and volunteers and ongoing staff development and training programs related to the responsibilities of each individual’s position.

**NOTE:** Provider agencies licensed by the Healthcare Facility Regulations Division must comply with all rules and regulations related to certification and/or training in cardiopulmonary resuscitation, emergency first aid, and continuing education.

B. The provider must furnish all staff development and training opportunities related to the performance of their jobs. In addition, provider staff and volunteers, if applicable, must attend Division of Aging Services training sessions as requested or required.

C. Providers must develop an ongoing in-service training plan and schedule for staff, subcontracted individuals, and volunteers. For all CCSP services except ERS and HDM, the plan must include, at a minimum, the following topics:

- orientation to the agency
- CCSP overview including program policies and procedures
- sensitivity to the needs and rights of older individuals
- re-certification and/or training in techniques of first aid and cardiopulmonary resuscitation (CPR)
- member rights/Elder Abuse Reporting Act/Advance Directives
- Personnel Code of Ethics
- Business Ethics
- infection control procedures (see Appendix Q of the CCSP General Manual)
- fire safety and accident prevention and safety
- confidentiality of member information
- medication management
- disaster planning/emergency procedures
- caring for members with Alzheimer's and related illnesses.

The provider must establish and maintain records to document the implementation of the training plan including, the name(s) and credentials of the trainer(s), training date, content, length of time and persons attending for each training.

For ERS and HDM providers, in-service training must include orientation to the agency, CCSP policies and procedures, and other service related training as required.

D. All administrative and non-direct member care staff will demonstrate awareness and working knowledge of the topics listed in section 607.5C of the CCSP General Manual. In addition, all administrative and non-direct member care staff will receive training in:

- Business Ethics
- Financial Planning
- Medicaid Waivers
- Medicaid and Medicare Benefits

E. The CCSP provider will establish and maintain records that document the orientation and on-going staff development and training of each individual. The records will, at a minimum, include:

- the topic presented
- the name(s) and credentials of the trainer(s)
- the training date,
- the length of time of the training
- an outline or description of the content of the training
• the name of each individual who attended the training

F. ERS and HDM providers will include an orientation to the agency, CCSP policies and procedures, and other service related training as required for the orientation and staff development and training for their employees/staff, subcontractor’s and volunteers.

608. **Environmental Safety Procedures**

608.1 **Disaster Preparedness**

The provider must establish and maintain written policies and procedures for members and staff to follow in the event of a disaster, to include procedures to see that care is provided during emergency situations (e.g., flood, fire, bomb threat, etc.) that may impede the provider's ability to reach members' homes. (Refer to Rules and Regulations for Disaster Preparedness Plans, Chapter 290-5-45). Procedures for disasters occurring at a CCSP facility must also be included.

A. **Triage Levels**

The provider establishes and maintains policies and procedures for assuring that a system of contingency plans for emergencies or disasters is in place. These plans will assure back-up care when usual care is unavailable and the lack of immediate care would pose a serious threat to the health, safety, and welfare of the member.

These policies and procedures should provide uninterrupted service according to the priority levels identified by the care coordinator for each member enrolled in the CCSP. These policies and procedures include:

- Delivery of member service(s).
- Staff assignment and responsibilities.
- Names and phone numbers of the Division of Aging Services, Area Agency on Aging, care coordination staff., and if applicable, the Healthcare Facility Regulations Division and Long Term Care Ombudsman.
- Notification to care coordination, attending physicians, and responsible parties.
- Availability of members’ records.

Emergencies include, but are not limited to, the following:
Inclement weather (heavy rains, snow storm, etc).

Natural disasters (flood, tornado, hurricane, ice storms, etc.).

Major industrial or community disaster (power outage, fire, explosion, roadblocks).

Agency employee illness or severe staffing shortage affecting significant number of employees.

Damage, destruction or fire at the agency's location.

Remote areas where transportation would be limited.

Suspected abuse, neglect and/or exploitation.

Communication with care coordination is an essential component to this process. Using the Community Care Notification form, (CCNF), the provider will notify the care coordinator if he is not in agreement with the assigned Triage level. Assigned Triage levels will be documented in the comment section of the Comprehensive Care plan. Care coordinators will use the following to assign Triage levels.

**Level One members:**

- Require only minimal amount of care
- Require less complex treatments and/or observation and/or instruction
- Provide self-care, ADLs, or have a willing and able-bodied caregiver
- Do not exhibit any unusual behavioral problems

**Level Two members:**

- Require an average amount of care
- No longer experiencing acute symptoms
- Require periodic treatments and/or observation and/or instruction
- Require some assistance with ADLs, require help for limited periods, or have willing and capable caregivers
- Exhibit some psychological or social problems

**Level Three members:**

- Require an above average amount of care
o Require daily treatment and/or observation and/or instruction
o Have willing caregivers whose capabilities are limited
o Require assistance with ADLs
o Ambulate with the assistance of two people
o Exhibit disorientation or confusion

**Level Four members:**

o Require a maximum amount of care and have no caregivers in the home
o Exhibit acute symptoms
o Are confined to bed
o Require complete care
o Require treatment and/or procedures necessary to sustain life

B. **Staff Training and Drills**

- The provider must assure that all staff members are provided ongoing training in disaster preparedness. The training program must include drills so that employees are able to promptly and correctly carry out their assigned roles in case of a disaster.

- Disaster drills must be conducted at least annually and must be documented as to date, time, staff/member participation, problems, and action taken to prevent problems from recurring.

C. **Posting of Instructions**

- The provider posts emergency instructions and evacuation routes in a prominent place in each room of the facility and orients all members to these routes.

608.2 **Evacuation Procedures**

Evacuation drills must be conducted at least every other month in all CCSP facilities and must be documented. A designated place for members and staff to meet outside the facility following evacuation must be described in the written disaster procedures. One or more staff members must be assigned to make sure everyone is out of the building.

608.3 **Smoking Control**
If RC, ADH, and ALS providers permit smoking in a facility providing CCSP services, the provider must designate a separate and distinct smoking area. All smoking is confined to the designated area.

609. **Program Evaluation**

609.1 **General**

The Georgia Departments of Human Services and Community Health monitor program administration and perform utilization reviews of member services and care. Providers will develop a written continuous quality improvement plan that addresses how the agency determines the effectiveness of services, identifies areas that need improvement, and implements programs to improve services and quality of care.

609.2 **Program Evaluation and Customer Satisfaction**

A. Providers must establish and adhere to policies for program evaluation and conduct comprehensive reviews of their programs at least once a year. Provider agency administrative and program staff, members, and members’ representatives participate in the review.

The provider agency will determine who will conduct self-evaluation reviews and will establish written policies and procedures for conducting them. At a minimum, the comprehensive program evaluation consists of a review of the agency's administrative policies and procedures, members' clinical records (available to authorized staff only), and members' satisfaction with services.

1. **Policy and Administrative Review**: The provider reviews policies and procedures at least annually and revises them as needed. The provider indicates in policy how changes in agency policies and procedures are communicated to all staff.

2. **Clinical Record Review**: The provider will monitor and review a 25% random sample or a minimum of 50 records (both active and closed clinical records), whichever is less, to:
   - assure that staff follow established policies and procedures in providing services
   - determine the adequacy of member care plans
   - determine the appropriateness of staff decisions regarding the particular care ordered for members.

   The review must include a summary of the program's effectiveness and a plan and time frame to correct deficiencies. The provider must
maintain review results in the administrative files and keep them available for review when requested.

3. **Member Satisfaction:** The agency must conduct quality improvement activities which include collection, measurement and evaluation of member satisfaction with the services provided by the agency. The member satisfaction review must include direct communication with members. The provider agency’s quality improvement activities must include:

- publication of a local or toll-free telephone number for a designated staff person responsible for addressing quality improvement issues, member complaints, and conducting ongoing member satisfaction activities. The contact telephone number must be distributed to all CCSP members and/or member representatives
- routine assessments of member satisfaction during supervisory visits. For frequency, refer to the requirement for supervision indicated in each service-specific manual.
- collection and analysis of feedback regarding service staff reliability, responsiveness, competency, empathy, and courtesy
- specific time frames for reporting, investigating and resolving service complaints
- specific activities for addressing results of quality improvement activities.

B. The provider maintains a written report describing the findings of the evaluation and any corrective action taken. The provider must document follow-up to assure the issues have been resolved.

### 609.3 Program and Administrative Monitoring

The Division of Aging Services uses results of monitoring by various entities to determine provider compliance with CCSP requirements.

A. The Division of Aging Services or its representative will monitor providers to ensure compliance with program and administrative requirements. If needed or requested, the Division of Aging Services provides technical assistance.

B. The DCH conducts utilization reviews and audits.

C. The Healthcare Facility Regulations Division issues permits and licenses for personal care homes, private home care providers, and home health
agencies. In addition, the HFR investigates complaints and conducts inspections to determine ongoing compliance with licensure requirements.

609.4 **Utilization Review**

A. The DCH performs periodic Utilization Reviews of CCSP member services to assure the medical necessity for continued care and the effectiveness of the care being rendered. Each provider is reviewed as frequently as deemed appropriate or necessary, with on-site reviews or audits sometimes conducted with no prior notice.

B. During each review visit, the DCH examines member records and conducts in-home or on-site individual member assessments.

1. The DCH examines member records to assure that they contain the following:
   
   - a current Level of Care and Placement Instrument that is signed, dated, certified, and initialed
   - physicians' orders if applicable
   - provider care plans
   - documentation of services provided, their frequency, and appropriateness of service revisions
   - documentation of supervisory visits.

2. The DCH conducts on-site assessments of members to determine if the member's condition warrants continuation of the current level of services rendered by all providers. The assessments determine whether:
   
   - additional needs exist
   - care provided is adequate
   - services have been effective
   - alternative methods of care should be considered

C. The DCH routinely provides the Division of Aging Services with copies of Utilization Review reports. Division of Aging Services CCSP Section staff members reviews each report and the provider's written response to all deficiencies cited in the report.
D. Upon completion of the on-site visit, the DCH forwards to the provider a written report of the Utilization Review findings. The provider must submit a corrective plan of action to the DCH and the Division of Aging Services within fifteen (15) calendar days of the date of the utilization review report. The provider's failure to comply with the request for a corrective plan of action may result in adverse action, including suspension of referrals or termination from the program.

E. When Utilization Review reports include recommendations for changes in member services, the DCH will mail the report to the provider five business days prior to mailing the member letter(s). The member has the right to appeal any adverse action recommendations made by the DMA. Adverse actions imposed by DMA include:

1. reducing service(s)
2. terminating service(s)
3. determining service is inappropriate
   
   o If the member appeals by filing for a hearing within ten calendar days of the date of the member letter, the member may continue to receive services until the Administrative Law Judge (ALJ) makes a decision. Providers must consult with the care coordinator to confirm that the member has requested a hearing within ten calendar days and wishes to remain in service. The DCH will reimburse the provider for services rendered during the DHS hearing process if the member's request for hearing was filed within the ten calendar day limit.

   o If the member does not file for a hearing within ten calendar days of the adverse action letter, the DCH's recommendation becomes effective at the end of the ten calendar days as stated in the utilization review report and the DMA notice to the member. However, the member has the right to request a hearing within 30 calendar days from the date of the member's letter. (See Appendix M of the CCSP General Manual).
PART II - CHAPTER 700
ELIGIBILITY CONDITIONS

701. **General**

The DMA reimburses enrolled providers for CCSP services provided to eligible persons only. Eligible persons are those who:

1. have been determined Medicaid eligible or potentially Medicaid eligible
2. have been assessed appropriate for the Community Care Services Program by the care coordinator
3. are certified for a level of care appropriate for placement in an intermediate care facility
4. are in need of service(s) which can be provided by the CCSP at less cost than the Medicaid cost of nursing facility care

**NOTE:**

A member may **NOT** participate in more than one Medicaid waiver program at the same time. However, a provider may participate in more than one Medicaid waiver program.

Medicaid Waiver Programs include:

- Community Care Services Program (CCSP)
- Independent Care Waiver Program (ICWP)
- Community Model Waiver
- Service Options Using Resources in the Community Environment (SOURCE)
- Shepherd Care Project
- Georgia Pediatric Program (GAPP)
- Comprehensive Supports Waiver (COMP formerly CHSS)
- New options Waiver (NOW formerly MRWP)
- Deeming Waiver (Katie Beckett)

702. **Verification of Medicaid Eligibility**

**Medicaid Eligible Members**

The care coordinator must verify a member's Medicaid eligibility prior to brokering services with a provider. The provider verifies eligibility monthly thereafter by checking the member's Medicaid card at [www.mmis.georgia.gov](http://www.mmis.georgia.gov). **A copy of the Medicaid Card is included in Appendix BB.** If the member is
ineligible for Medicaid benefits, the DMA does not reimburse a provider for services rendered. Refer to Section II of the DCH Part I Policies and Procedures Manual’s Billing Appendix for additional methods to check Medicaid eligibility.

PMAO Members

Care coordinators broker potentially medical assistance only (PMAO) members with providers. Providers may not bill Medicaid for services rendered to PMAO members until the care coordinator has issued SAFs reflecting the member’s Medicaid member number.

In cases of lost or stolen Medicaid cards or other emergency situations, a provider may verify Medicaid eligibility for the current month by calling the Verification Unit at the Division at 1 (800) 766-4456.

To verify Medicaid eligibility for past months, a provider may request information in writing from:

Division of Medical Assistance
Medicaid Card Control Unit
P.O. Box 38435
Atlanta, Georgia 30334

The request must include the following information:

1. Member's name exactly as it appears on the Medicaid card
2. Member's Medicaid or Social Security number
3. Member's birth date
4. Dates for which the provider is requesting verification
5. Return address of provider agency

Note: Refer to Section 606.21 E of the CCSP General Manual.