POLICIES AND PROCEDURES

for

Services Options Using Resources in Community Environments

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

DIVISION OF MEDICAID

January 1, 2019

Policy Revisions included in the January 2019 Edition of the SOURCE Policy Manual

Policy Revisions included in the January 2019 Edition of the SOURCE Policy Manual

Second Page

1/1/2019	607	Add wording to expansion	There will be an audit requirement for any Case Management agency that requests an expansion.	Policy Update
1/1/2019	701	Added Note	Note regarding GAPP added	Policy Update
1/1/2019	807m	Removed	Removed working regarding complaint log leading to corrective action	Policy Update
1/1/2019	902 a	Change to Policy	Changes to Standard of Promptness for assessments	Policy Update
1/1/2019	902 e	Added wording	Appendix T is added to the upload to AHS at Initial Assessment	Policy Update
1/1/2019	902 n	Change to policy	Changes to Standard of Promptness for assessments	Policy Update
1/1/2019	903	Added Wording	Appendix T is added to upload to AHS. Also the AHS upload list is added to the initial assessment section as it is already in the reassessment section.	Added to policy
1/1/2019	Appendix T	Wording changed	RN Who Reviewed MDS HC for Consistency and Completeness (Printed)	Update
1/1/2019	Appendix OO	Form added	MMSE added to Appendix OO for choice of exams.	Added

Policy Revisions included in the October 2018 Edition of the SOURCE Policy Manual -

Second page

10/1/18	1302 D	Changed wording	Changed wording to Medical Director from PCP on signing carepath	Update Policy
10/1/18	1303	Removed wording	The word quarterly was changed to last visit.	Update Policy
10/1/18	1304	Changed wording	Wording changed from quarterly conference to bi-annual conference	Update Policy
10/1/18	App Z Forms Manual	Section 1E	Removed wording for discharge for Level of Care as it comes from AHS	Removed
10/1/18	App. Z Forms Manual	Physician Level of Care concurrence	Removed the Physician Level of Care Denial Concurrence Form Removed	Removed
10/1/18	APP. EE Forms Manual	Update and add	Address change for ACE Case Management and added new provider On My Watch	Change
10/1/18	App. NN Forms Manual	Removed	Form NN removed in liu of using PCP Medical Records.	Removed
10/1/18				
10/1/18				

Policy Revisions included in the October 2018 Edition of the SOURCE Policy Manual

10/1/18	606, 608,807 App.CC	Updated	Reference to HP changed to DXC	Name Change
10/1/18	ALL	Changes	All References to GMCF have been changed to AHS as they are going by Alliant Health Solutions	Name Change
10/1/18	APP DD Forms Manual	Rate Increase	Updated rates for ADH and ALS, both Group and Family Models	Rate Change
10/1/18	1415	Added	Information on Georgia Families add to the Manual	New Information
10/1/18	803 D & G	Updated	Additions made to Medical Director duties	Changes from PCP
10/1/18	902	Removal	Removed language regarding Provisional LOC from DCH	Removed
10/1/18	1003	Updated	Changed Primary Care Provider to Medical Director throughout the carepath completion.	Updated
10/1/18	1200	Updated	Changed quarterly to bi-annual	Updated
10/1/18	1302 C7	Removed wording	Removed the wording on 3 quarter for exam as it is no longer required to go to AHS at reassessment.	Removed

Policy Revisions included in the July 2018 Edition of the SOURCE Policy Manual -
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7/1/2018	App HH	Removed	Rotation Log and information has been removed	Removal
7/1/2018	App HH	Update	Provider Complaint Log has been updated and corrective action for a provider updated.	Policy Update
7/1/2018	App JJ	Update	Changed wording to clarify documentation of Flu Shots	Clarification
7/1/2018	App LL	Update	Changed from 10 day to 30 days for agency to send information to AHS for 2nd nurse review.	Policy update

Policy Revisions included in the July 2018 Edition of the SOURCE Policy Manual -

7/1/2018	807	Update	Removed the monthly scoring	Change to policy
7/1/2018	903	Update	Sentence on Incomplete Assessment rewritten for clarification. Appendix C removed from the list of forms to send to AHS	Clarification and Change in Policy
7/1/2018	905	Update	Changed wording to clarify Appendix F to be sent	Clarification
7/1/2018	1100	Update	Changed to …Client choice using Appendix C 1	Policy update
7/1/2018	1411 & App.H & AA	Update	Updated to notify of Sentinel event in 24 hours via email and send completed Sentinel event within 5 business days	Policy changed
7/1/2018	1414 & App RR	New	BIP information removed from Appendix RR and added to Policy body	Appendix removed and put in Body of Policy
7/1/2018	App. C	Update	Appendix C Assessment addendum is Optional	Changed Form
7/1/2018	App C 1	New	Current C6 has been changed to the SOURCE Member Choice of Provider Form.	New Form
7/1/2018	App EE	Update	Updated list of counties for Ace, VNHS, Diversified, Legacy Link, and Next Step. One office change for Next Step.	Clarification

Policy Revisions included in the April 2018 Edition of the SOURCE Policy Manual

4/1/2018	801	Update	To add Level of Care start date to the day of the assessment on initial clients to be able to bill for the assessment month	Added to policy
4/1/2018	905	Update	Modified Assessment use re-written for clarity	Clarification
4/1/2018	906	Update	Transfers of SOURCE clients re-written to keep in line with all waivers	Clarification
4/1/2018	1404	Update	Number 8 and number 10 removed from discharge policy	Policy update
4/1/2018	1412	Removed	Policy was taken out and all transfer policy information is under 906	Policy Removed
4/1/2018	App. EE	Update	Change of address and counties added to Crossroads	Change of address
4/1/2018	App. QQ	New	New version of Appendix QQ, Modified Reassessment	New Form

1/1/2018	608	Update	Removed the statement that service providers must be a CCSP provider for 6 months prior to becoming a SOURCE provider	To match DCH General Services
1/1/2018	701	Update	Changed the word "or" and replaced with "and" between ADL and IADL in eligibility statement	Clarification
1/1/2018	807	Update	Changed the word "or" and replaced with "and" between ADL and IADL in eligibility statement.	Clarification
1/1/2018	903 Program Adm.	Update	Added word "Form" following Medication Record.	Added to policy
1/1/2018	App: SS	Added	Appendix SS is the Medication Record Form	Added to policy
1/1/2018	App: EE	Update	SOURCE Case Management list updated with current information on Address and Phone Numbers	Updated
1/1/2018	App: DD	Update	Updated Rates for Services	
			.	

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REVISION DATE	SECTION	REVISION DESCRIPTION	REVISION TYPE A=Added D=Deleted M=Modified	CITATION (Revision required by Regulation, Legislation, etc.)	Reason for change
1/2016	904	**Routine Reevaluations/ Reassessments** **plete Re Evaluation Packets)** ***r the sentence that states:*** "Source members are evaluated for continued eligibility at least annually, and more often as necessary (e.g. improvements, as directed by AHS, as directed by DCH). " *Transfers excluded from this statement*	D	N/A	Consistency in policy
1/2016	905 Modified Reevaluation/ Readmission into SOURCE	Members with a greater than 3 month LOC do not have to have an evaluation packet submitted to AHS. If a transfer, submit appendix X	A A	N/A	Relieve burden on CM agency
1/2016	905 Modified Reevaluation/ Readmission into SOURCE	Members who meet certain requirements, may qualify for a modified evaluation packet.	A	N/A	As above
1/2016	Section 904 and Appendix QQ	New form/ form requirements for Modified reevaluation	A	N/A	Assist in clarification of new policy
1/2016	1406 Right to appeal	If agency discharges a member, and member appeals, AHS requires the evaluation packet to be uploaded to AHS to extend the LOC thru the hearing process. Clearly ID packet as agency denied	A	N/A	AHS requirement
4/2016	701. Eligible Members	Need to determine eligibility factors annually or more often	A	N/A	Clarification
4/2016	1404	Removed all references to notify DCH with an appendix F for member discharges…	D	N/A	No longer applicable
4/2016	Appendix F Provisional Level of Care	Provisional Level of Care removed. This process no longer applicable with newly implemented PA Service process	D	N/A	N/A for program

4/2016	Appendix Z (pages 6 and 7)	Forms updated for discharge planning and any References in manual to Appendix Z specific pages updated to reflect new documents	M/A	N/A	update
4/2016	Appendix Z page 6	Form needed for legal updated	M	N/A	update
4/2016	1404.Member Discharge	*Discharge **Planning** Policy Statement added and*	A	N/A	Consistency
REVISION DATE	**SECTION**	**REVISION DESCRIPTION**	**REVISION TYPE**	**CITATION**	**Reason for change**
4/2016	1404 Member Discharge	Reinforcement of steps for discharge planning: Upon discharging the member, the Case Manager will complete the SOURCE Discharge Summary Form in its entirety (Appendix BB), and Appendix - 8 to be filed in the member's chart.	A	N/A	
4/2016	806 SOURCE CASE MANAGEMENT TEAM	Each SOURCE Enhanced Case Management Team convenes a formal multidisciplinary team meeting at least weekly, to perform the following functions a) Review new admissions b) Complete / Review Discharge Planning (see Appendices) for new members, reassessed and discharging members	A	N/A	
4/2016	Appendix H	New SOP for provision of resources to members with an involuntary discharge and follow up with member	A	N/A	Continuity
4/2016	Appendix BB	Discharge planning information added	A	N/A	Consistency
4/2016	1405 SOURCE MEMBER INVOLUNTARY DISCHARGE	2 The Case Manager will state that program eligibility requirements and reevaluation is needed to remain on the SOURCE program	A	N/A	Member help
4/2016	1406. Right to Appeal	**Procedures after decision of non-eligibility:** a 2nd level review option will be present in the AHS letter to members. How it works is described.	A	N/A	Member help
4/2016	Appendix MM	**How to attach the new information to AHS in a 2nd level appeal**	A	N/A	Member help
4/2016	APPENDIX LL AHS	*Provider Workspace User Manual* that will show SOURCE Providers how to submit Second Level Reviews/ Reconsiderations. How providers should	A	N/A	Program advance

		submit additional documentation for Second Level Review/ Reconsideration via the Reconsideration Link ONLY.			
7/2016	1404. Member___ Discharge	**(under) Procedures:** **(8) SOURCE** Medical Director will sign Appendix F for discharge of services.	**M**	**N**	**clarification**
7/2016		**(under) Process for Discharge** Member is chronically non-compliant (non-compliance includes continued abuse of alcohol or drugs)	**M**	**N**	**clarification**
REVISION DATE	**SECTION**	**REVISION DESCRIPTION**	**REVISION TYPE**	**CITATION**	**Reason for change**
7/2016	**Appendix KK**	Skilled Nursing Services RN: $65.00 per visit/ only one visit per day maximum	**M**	**N**	**clarification**
10/2016		**No changes**	**—**	**---**	
1/17	**New Appendix added (RR)**	**Conflict Free Case Management**	**A**	**Y**	
1/17	**New information added 603 Core Refinements**	a) **Case Management Agency included and wording updated to say:** SOURCE measures the performance of Case Management Agencies and providers of community services … Adequate, Competent, Consistent, Compatible staffing	**M**	**N/A**	
1/17	**1400**	**Statement on Conflict Free Case Management p**	**A**	**N/A**	**Regs**
1/17	**1401**	**Statement on Conflict Free CM**	**A**	**N/A**	**Regs**
1/17	**Appendix NN**	**Revised form to One Page and PCP attestation removed.**	**M**	**N/A**	
1/17	**Appendix X Transfer Form**	**Form revised to universal with ANS requirements. Electronic available upon request.**	**M**	**N/A**	**clarification**
04/17		**No Revisions for APRIL 2017**		**N/A**	
07/17	**Appendix DD SOURCE National Codes and Rates**	**Update to ADH rates (retroactive to 07/01/2016)**	**M**	**L**	**Legislative update**
		July 2017 Updates			
7/17	1404.Member Discharge				
	Process for Discharge	Member can be kept on Program for up to 100 days in anticipation of discharge from a medical facility (no longer requires an immediate discharge)	**M**	**N/C**	**Consistent with CCSP**

	Procedures	Case Management may Suspend the Service PA if NH or other medical facility admission is anticipated to be 100 days or less	**M**	**N/A**	**Consistent with CCSP**
	Procedures	**Procedure to suspend a service PA** (new section added)	**A**	**N/A**	
	Procedures (#10)	When and how to notify AHS that a discharge has occurred.	**M**	**N/A**	
	1405 Involuntary Discharge				
	Discharge occurs when (#5)	**Modified to say medical facility (instead of NH) and long-term nature of 21 days is removed to state 100 days**	**M**	**N/A**	**Consistent with CCSP**
	1406 Right to Appeal				
	Procedures for Issuing Discharge Notice from Case management Agency (#6)	**(***Discharge to nursing home does not require a 30day waiting period after the Z (Discharge, Termination) letter is sent; once Case Management decides it is appropriate to discharge the NH member from the Waiver, it is immediate. Refer to Section 1405-Involuntary Discharges*)	**M**	**N/A**	
	1412.Transfers between SOURCE Case Management Agencies				
	Procedures: A MEMBER must RE-LOCATE or TRANSFER to different Case Management **Agency**	8. The new agency will work with the transfer agency to submit a SOURCE Member Transfer Form (Appendix X) to AHS if a modified reevaluation is completed. If a full evaluation is needed, submit complete packet to AHS and indicate that is an external agency transfer. Transferring agency should upload form to AHS per contact us.	**Modified**	**NO**	**Clarification**
	Appendix DD	**Rate Increase for ADH (see appendix) documented with retroactive date**	**M**	**Legis**	

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Part II Policies and Procedures Manual for SOURCE Services

Preface

Part II Policies and Procedures Manual for SOURCE Services

PREFACE

Policies and procedures in this manual apply to all SOURCE Case Management Providers. All service providers must refer to Community Care Services Program for specific program requirements for policies and procedures specific to each service type, unless otherwise indicated by the SOURCE DCH Policy and Procedure Manual.

Part II	Chapter 1100	Adult Day Health
Part II	Chapter 1200	Alternative Living Services
Part II	Chapter 1300	Home Delivered Services
Part II	Chapter 1400	Personal Support Services
Part II	Chapter 1500	Out-of-Home Respite Care
Part II	Chapter 1600	Emergency Response
Part II	Chapter 1700	Home Delivered Meals

All SOURCE Case Management Providers and service providers must adhere to Part I – Policies and Procedures Applicable to All Medicaid Providers, unless otherwise indicated by the SOURCE Policy and Procedure Manual.

As used in this policy manual, unless the content indicates otherwise, the term:

Activities of Daily Living (ADLs) **–** include fundamental activities related to community living, such as eating, bathing/dressing, grooming, transferring/locomotion and toileting.

Caregiver (CG) **–** Person providing significant non-paid support to a SOURCE member; most typically a family member. Has formal or informal authority to receive information and participate in decision –making on behalf of a SOURCE member.

Carepath **–** A standardized set of expected outcomes for each SOURCE level of care, with an individualized plan for each member to achieve them. SOURCE Carepaths address risk factors associated with chronic illness and functional impairment. Replacing conventional HCBS care plans, SOURCE Carepaths provide structure and accountability for case management practices of a chronic care population.

Carepath Variance **–** When an expected Carepath outcome doesn't occur; a Carepath goal not met. Variances require action on the part of the Case Manager to ensure that issues are promptly resolved and goals will be met in the following review period.

Case Management Supervisor (CM Supervisor) **–** The staff member with direct supervisory authority over Case Managers; may also serve as Program Manager. Responsible for ensuring that CMs address Carepath variances and work in accordance with program goals. Assists CM in problem solving, reviews documentation and monitors provider performance.

Case Manager (CM) – The staff person serving as the SOURCE member**'s liaison and** representative with other program key players; the C**M's prima**ry responsibility is to ensure that goals of the program and of individual members are met. Performs functions of needs assessment, Carepath monitoring and coordination with other health system or social service personnel.

Case Note **–** An entry in a SOURCE member's chart by a Case Manager or Case Management Supervisor. Case notes document contacts with or on behalf of SOURCE members; actions taken on behalf of SOURCE members; or observations/follow-up planning by case management staff. Case notes should give the date, the person contacted, the setting and a description of the exchange. Case notes are used to note problems identified, to document resulting follow-up activity and to indicate when problems are resolved. Notes written on SOURCE Contact Sheets are considered case notes.

Community Care Services Program (CCSP) **–** Medicaid funded program in Georgia providing a range of community-based services to nursing home eligible persons, administered by the state's Department of Human Resources under a 1915 (c) waiver.

Community Services **–** The menu of possible services reimbursed through SOURCE according to the care path plan authorized by the site, provided in a home or community setting.

Community Service Provider **–** An organization participating in the program as a provider of community services authorized by the CM and reimbursed through SOURCE.

Concurrent Review **–** The process of regular and thorough review of essential information about individual SOURCE members, by a Case Manager and key players; used to ensure that Carepath and program goals are met.

Conflict Free Case Management: restricts the delivery of **Case Management** Support and Home and Community Based Direct Services by the same agency or entity.

DON-R- The Screening tool entitled Determination of Need- Revised.

Enhanced Primary Care Case Management – The service provided through the SOURCE program, blending primary medical care with case management and community services for Medicaid recipients with chronic illness.

AHS- Alliant Health Solutions, medical management vendor, subcontractor of DCH.

MDS-HC **–** Minimum Data Set Health Care – A Home and Community standardized assessment tool to determine Level of Care. SOURCE program uses Version 9.

Medicaid **–** A jointly funded, federal/state healthcare assistance program administered by the Division of Medical Assistance (DMA) under the Georgia Department of Community Health, serving primarily low-income individuals: children, pregnant women, the elderly, blind and disabled. SOURCE falls under DMA's Aging and Community Services.

Home and Community Based Services (HCBS) **–** Supportive services delivered in a home or community setting, as opposed to a nursing home or other institution. Personal care services and home delivered meals are examples of HCBS. In addition to a private residence, HCBS settings also include personal care homes and adult day health centers.

Instrumental Activities of Daily Living (IADLs) **–** include supportive activities related to community living, such as meal preparation, housekeeping, using the telephone, financial management, etc.

Key Players **–** Individuals or organizations bearing major responsibility for ensuring that program and Carepath goals are met: SOURCE members and/or informal caregivers, Case Managers, CM Supervisors, PCPs and service providers.

Member Information Form (MIF) **–** Form used to record communication between SOURCE Case Management Provider and SOURCE service providers. Required for documenting key exchanges (service level changes, etc.), the MIF may be initiated by either party.

Program Manager **–** The staff member responsible for ensuring proper implementation of all policies and procedures of the SOURCE program. Primary responsibilities include coordination among key players, developing site-specific policies and procedures, leading data analysis and serving as liaison with the Department of Community Health.

SOURCE Level of Care and Placement Instrument (Appendix F) **–** Document used to formally enroll Medicaid members into the SOURCE program.

SOURCE Member – A Medicaid recipient who is formally enrolled in the SOURCE Enhanced Primary Care Case Management program.

SOURCE Primary Care Provider (PCP) – The chief clinical partner in providing enhanced case management to SOURCE members; may be a physician or a nurse practitioner. Responsibilities include direct primary medical care and coordinating with other key players in the program. All SOURCE members must be under the care of a PCP participating in the program.

SOURCE Enhanced Case Management – The entity under contract with the Georgia Department of Community Health, Division of Medical Assistance, to provide the **"**enhanced primary care case management**" servi**ce described in this manual and in the SOURCE Memorandum of Understanding. Program components may be provided directly by the entity holding the contract or by sub-contract, but the site bears responsibility for implementation of program policies and procedures.

ABBREVIATIONS

Behavior **–** abbreviation for the behavior Carepath outcome

Clin **–** abbreviation for the clinical indicators/lab value Carepath outcome

Comm **–** abbreviation for the community residence Carepath outcome

EPCCM – abbreviation for Enhanced Primary Care Case Management

Housing **–** abbreviation for the housing Carepath outcome

Incont **–** abbreviation for the incontinence Carepath outcome

Inf support **–** abbreviation for the informal support Carepath outcome

Meds **–** abbreviation for the medication Carepath outcome

Nutr**'n –** abbreviation for the nutrition Carepath outcome

Skin **–** abbreviation for the skin Carepath outcome

Trans/mob – abbreviation for the transfer/mobility Carepath outcome

601. Introduction to SOURCE

SOURCE operates under authority of the Elderly and Disabled 1915-c Home and Community Based Services (HCBSS) Medicaid Waiver approved by the Centers for Medicare and Medicaid Services (CMS). Individuals eligible for enrollment in SOURCE must be eligible for full Medicaid (this excludes SLMB, QMB, and QI). Individuals served by SOURCE must be physically, functionally impaired and in need of services to assist with the performance of the activities of daily living (ADLs). Without waiver services, eligible SOURCE members would require placement in a nursing facility. While individuals, participating in SOURCE under the Elderly and Disabled waiver, do not have specific exclusions related to age, the waiver targets individuals who are elderly and physically disabled. SOURCE through its case management model, Enhanced Primary Care Case Management (EPCCM), links primary care to community services.

SOURCE Case Management Provider is enrolled with DCH to provide Enhanced Primary Care Case Management (EPCCM) services for eligible older and physically disabled Medicaid recipients. The model is comprised of three principal components – primary medical care, community services and case management – integrated by the site's authority to approve Medicaid-reimbursed services.

SOURCE sites receive an enhanced case management fee per member per month. Community and physician services for SOURCE members are covered under conventional Medicaid fee-for-service reimbursement with authorization by the site. For dually insured members, Medicare remains the primary payer for services traditionally covered by Medicare. While the SOURCE Case Management Provider is expected to coordinate services delivered under Medicare, no authorization is required for Medicare reimbursement. For services covered by Medicaid, in addition to community and physician services (hospitalizations, lab/diagnostics, co-pays for dually insured members, etc.), the SOURCE Enhanced Case Management authorization number may be required.

602. SOURCE Goals

Goals identified for SOURCE include:

a) Reducing the need for long-term institutional placement and increasing options in the community for older and disabled Georgians, by designing an effective model replicable across the state
b) Preventing the level of disability and disease from increasing in members with chronic illness
c) Eliminating fragmented service delivery through coordination of medical and long-term support services
d) Increasing the cost-efficiency and value of Medicaid Long Term Care (LTC) funds by reducing inappropriate emergency room use, multiple hospitalizations and nursing home placement caused by preventable medical complications; also by promoting self-care and informal support when possible for individual members

603. Core Refinements to Traditional HCBS

The SOURCE Program implements four core refinements to traditional HCBS programs:

b) SOURCE financially and operationally integrates primary medical care with the case management of home and community-based services.

c) SOURCE has developed and implemented a series of Carepaths for chronically ill persons (targeted conditions include: diabetes, high blood pressure, Alzheimer's Disease, dementia, stroke, heart disease, asthma or other

pulmonary conditions) at different functional levels, replacing the traditional HCBS care plan. Carepaths constitute a structured case management accountability system that regularly measures the achievement of key objectives for individual members, for the caseload of each Case Manager or Primary Care Provider and for the entire program. SOURCE measures the performance of Case Management Agencies and providers of community services by standards that exceed basic licensing requirements. Case Management Agencies and Providers of personal/extended support services (the most highly accessed category of service) will honor member and program expectations of:

Reliability of service, including early morning or late evening visits/care

Adequate, Competent, Consistent, Compatible staffing

Responsiveness to member and staff concerns, including the scope of care as described by the member or caregiver

Coordination --with Case Managers for the community service providers and Other Agencies for the Case Management Agencies

The Case Management and provider's role in achieving care path objectives – including member satisfaction with services – is regularly measured, addressed with performance improvement strategies as indicated and used to determine case assignments.

604. SOURCE Themes

The SOURCE vision of an ethical and disciplined community-based long term care system is described by several key themes that apply broadly to all members in the program (sites, members, providers, DMA):

a) Integration:

Empowerment via the authority to enforce expectations of key players by authorizing payments
Communication – scheduled and as needed to meet individual and program goals

Common objectives that keep members at the center

b) Member centered approach:

Member/family contribution and cooperation encouraged and valued
Advocacy for individual members, across all settings
Inclusiveness of varying ages, disabilities and functional capacities

c) Continuous improvement:

Collecting and reviewing data regularly to identify problem areas
Marshalling resources to help individuals address problems
Redesigning systems to help DCH address problems for chronic care populations

605. Partnership with DCH

All sites will maintain a partnership with DCH to continuously improve overall program performance and to ensure that individual sites are working toward stated goals. The partnership may be fulfilled by sites in several ways:

a) Participation at scheduled meetings with DCH staff to discuss program guidelines, performance improvement strategies and site-specific updates
b) Monthly reporting to DCH on program activity due on the 15th of the month following the reporting period
c) Compliance with quality assurance protocols for waiver programs developed for CMS by DCH

> DCH maintains oversight of all program components and reserves the right to give final approval of all aspects of the program including determination of eligibility and ILOC.

606. Enrolling as a SOURCE Enhanced Case Management Provider

Due to the complex nature of SOURCE and the fragility of the population, only established businesses with a history of providing case management may enroll. Other stipulations are as follow below and in Appendix FF

A. SOURCE contractors receive a per member, per month case management fee billed on the CMS 1500, in return for providing Enhanced Primary Care Management.

Enrollment for EPCCM requires completion of the Medicaid enrollment application located at the DXC web portal www.mmis.georgia.gov. The SOURCE Enhanced Case Management Application, which is included in Appendix FF-must also be completed. Completed applications should be mailed to:

Department of Community Health, Long Term Care Section, 2 Peachtree Street NW, 37th Floor, Atlanta, GA 30303.

B. Compliance – Applicants must demonstrate maintenance of a satisfactory record of compliance with federal and state laws and regulations, and must not be currently or previously prohibited from participation in any other federal or state healthcare program or have been convicted or assessed fines or penalties for any health related crimes, misconduct, or have a history of multiple deficiencies cited by Utilization Review and/or deficiencies that endanger the health, safety, and welfare of the member.

In addition, the provider agency must have no deficiencies within the past 3 years from any licensing, funding, or regulatory entity associated with enrollment in any Medicaid services, or with the provision of any related business unless such deficiencies have been corrected to the satisfaction of the imposing entity.

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

D. Application Review - DCH will approve new applications for EPCCM Providers based on the following criteria:

- Successful completion of the provider application located on the DCX website: mmis.georgia.gov

- Successful completion of the EPCCM Application (see Appendix FF)
- If DCH is unable to recommend approval of the application as submitted, the applicant will be notified in writing (including electronic mail) that the Department of Community Health (DCH) has denied the application.
- DCH will conduct site visits, if applicable. If the site visit results in unsatisfactory review, DCH will deny the enrollment application.
- If the application is denied, DCH will notify the applicant of the reason for the denial. Applicant agencies have the right to appeal enrollment denial as indicated in Part I, Policies and Procedures for Medicaid/Peachcare for Kids Manual.
- If the enrollment material meets submission and enrollment requirements, and no other information is required, the applicant will be notified in writing by DCH of its approval to become an EPCCM Agency.

NOTE: Applicant may not re-apply as an EPCCM for one (1) year after date of enial

607. Expansion Procedures

Prior to opening any new office or expansions to additional counties by an existing office, all sites that have been previously approved for SOURCE Enhanced Primary Care Case Management (EPCCM) must submit an expansion application to the Department of Community Health, Long Term Care Section for review and approval (see Appendix GG)

Department of Community
Health Long Term Care Section
Two Peachtree Street N.W.
37th Floor
Atlanta, Georgia
30303

NOTE: Newly approved EPCCM Sites may not apply for additional counties for six (6) months after date of approval.

Note: There will be an audit requirement for any Case Management agency that requests an expansion of their service area. A negative audit can result in a denial of the expansion and a ban on new admissions applied as corrective action until the agency regains compliance. Providers seeking expansion are required to be in compliance with all applicable laws, rules, regulations, policies and procedures of all services the provider is currently enrolled to provide. DCH will not process an expansion request for a provider against whom there are unresolved complaints/deficiencies cited by Utilization Review/ Program Integrity or other licensing or regulatory agencies.

Note: New provider EPCCM agencies as well as Expansion EPCCM agencies that have more than one location must have a separate provider number for each approved location

608 Community Service Provider Enrollment Procedure

A. All participating SOURCE providers must first be enrolled as a CCSP provider for the same services.
B. Please note that a separate SOURCE provider number must be obtained prior to rendering services.
C. Providers must complete the follow enrollment steps:
    1. Complete the Facility Enrollment Application located on the DXC website: www.mmis.georgia.gov
    2. Attach the documentation found listed on the Checklist found in Appendix II to the Facility Enrollment Application.
    3. Mail the completed provider enrollment packet to:
        Department of Community Health
        2 Peachtree Street, N.W.
        37th Floor c/o SOURCE Program
        Atlanta, Georgia 30303
    4. Or scan and email to tunderwood@dch.ga.gov
    5. Please put SOURCE Enrollment in the subject line.

D. DCH will review the SOURCE Provider applications to determine if enrollment materials meet submission and enrollment requirements. If no further action is required, DCH will notify the applicant of approval of the Medicaid enrollment.

E. DCH will distribute the Community Service Provider's information to appropriate Source agencies in applicable counties to be placed on the Active Provider log.

F. Once Community Service Providers have a SOURCE member, the provider must attend regular meetings with SOURCE and other contract expectations as outlined in this manual and the CCSP manuals.

G. Non-compliance maybe associated with suspension/ removal from the Active Provider log/list.

D. Providers must complete the following enrollment

SOURCE Eligible Members

701. Eligible Members

SOURCE operates under authority of the Georgia Elderly and Disabled 1915c Medicaid Waiver. For core waiver requirements see section 801.3-- The target population for SOURCE are physically disabled individuals who are functionally impaired, or who have acquired a cognitive loss, that results in the need for assistance in the performance of the activities of daily living (ADLs) and instrumental activities of daily living (IADLs); these individuals must meet the Definition for Intermediate Nursing Home Level of Care (LOC). Eligibility factors must be met annually or more often per guidelines in this manual, referenced manuals and the federal Waiver.

a) Aged 65 and older, or under 65 and physically disabled
b) Receiving full Medicaid (this excludes SLMB, QMB, QI)
c) Eligible based on meeting criteria for Intermediate Nursing Home Level of Care
d) Cost of necessary services can be provided by SOURCE at less cost than the Medicaid cost of nursing facility care
e) Willing participants who choose enrollment in the SOURCE Program (Member choice)
f) Residing in a SOURCE Enhanced Case Management's designated service area; and
g) Capable, with assistance from SOURCE and/or informal caregivers, of safely residing in the community (with consideration for a recipient's right to take calculated risks in how and where he or she lives)

NOTE: Medicaid eligible members under the age of twenty-one (21) will be referred to Medicaid's GAPP (Georgia Pediatric Program) to be screened for medically necessary skilled nursing and or medically necessary personal care support through Medicaid's State Plan services. As the Department moves to evaluate children on the waiver and compliance with federal mandates, continuity of care will be the first concern.

Member General Exclusions

- Members currently enrolled as members in the Georgia Families program (this is not the Georgia 360^0 program)
- Members with retroactive eligibility only and members with presumptive eligibility
- Children with severe emotional disturbances whose care is coordinated under the PRTF program
- Members of a federally- recognized Indian Tribe
- Qualified Medicare Beneficiaries (QMBs) without SSI (or full Medicaid);
- SLMB or QI without SSI (or full Medicaid)
- Members Residing in an Institution
- Members not meeting eligibility requirements
- Programs or Waivers that would cause duplication or services*

*Dual Waiver Enrollment Exclusions and Allowances:

In some instances, SOURCE members are allowed to participate in more than one waiver or program. There are still some Waiver and program exclusions. In the instance where a member would need to choose, individuals have the option of transfer from one waiver to another, contingent upon eligibility and available funding.

Exclusions from enrolling in two Waivers/Programs:

A member enrolled in SOURCE cannot receive duplicate services. Medicaid Waiver Programs that would cause duplication of services or excluded.

Waivers or programs where the member would need to be enrolled as an inpatient/ or in an institution are excluded from SOURCE.

All members considered for SOURCE must meet all SOURCE eligibility requirements.

Examples of Exclusions:

- Members who are, at the time of application for enrollment or at the time of enrollment, domiciled or residing in an institution, including skilled nursing facilities, hospital swing bed units, hospice inpatient, intermediate care facilities for people with developmental disabilities, or correctional institutions
- CCSP, Independent Care Waiver, the NOW and COMP Waiver Programs members are excluded

Allowances:

The SOURCE agency continues to assume full responsibility for the professional management of the individual's SOURCE care in accordance with the SOURCE manual. When an individual enrolled in SOURCE elects a second program or when an individual in another non-excluded program elects SOURCE: See lists below for allowances:

- SOURCE dual enrollment in GAPP may be permitted
  Please refer to the GAPP manual for more information

- SOURCE dual enrollment in Hospice may be permitted without duplication of services.
  PSS services and Skilled Nursing are not a covered service from the SOURCE provider.
  An individual or a child currently enrolled in a Medicaid waiver program that is diagnosed with a terminal illness may elect to enroll in the Hospice program. Please see Community Care Services General Manual section 901 Covered Services for more information

- Children Receiving Services under Title V/CMS without duplication of Services may be permitted

  Caution should be given for children in this category, member must demonstrate all eligibility requirements including a need for SOURCE services.

Procedure for Dual Enrollment:

If dual enrollment is desired by the member and meets the guidelines above (and of course all eligibility requirements) the agency should follow these procedures:

A) The member's SOURCE team and the 2nd program's case manager and member must communicate, establish, and agree upon a coordinated plan of care for both providers that prevents duplication of services. Distinct Case management services must be agreed upon to be given by each CM agency. Information on these areas is documented at the beginning of the relationship and quarterly. More frequent communication should be documented if the need arises.

B) Both companies must keep records that indicate: that multiple Medicaid plans of care have been coordinated. Failure to demonstrate this coordination will be considered a failure to comply with the terms of this policy. As such, lack of evidence of coordinated care in documentation will result in a terminated lock-in and any paid claims for services will be subject to recoupment.

C) If Hospice is the designated 2nd program, the hospice agency MUST be the provider of the skilled nursing and personal support services. SOURCE may provide extended personal support services (in-home respite).If SOURCE member is in a PCH, the PCH must continue to give all care and not designate the normal care of a member to the Waiver such as hospice

D) All hospice services must continue to be provided directly by hospice employees. The services cannot be delegated. When the member is in a waiver program residential facility (SOURCE Personal Care Home), the hospice agency may involve the facility staff in assisting the administration of prescribed therapies that are included in the plan of care; this is only to the extent that the hospice would routinely utilize the service of the patient's family/caregiver in implementing the plan of care.

E) When the member is a resident in a waiver program's residential facility, the facility must continue to offer the same services to the individual that elects the hospice benefit. The hospice member should not experience any lack of facility services because of his/her status as a hospice member.

The following activities are not allowed by SOURCE providers of any type:

SOLICITATION OF MEMBERS FOR THE SOURCE PROGRAM
This includes:

- Developing Carepaths, using amount or frequency of services, to encourage member choice of providers
- Soliciting clients from other providers or other programs

Neither SOURCE case management providers nor HBCS providers shall solicit Medicaid members for the purpose of rendering SOURCE services, following the policy outlined in:
Part I, Policies and Procedures for Medicaid/Peachcare for Kids-- which all Medicaid providers agree to follow. The policy states:

> *106. General Conditions of Participation*
>
> *E) Not contact, provide gratuities or advertise "free" services to Medicaid or PeachCare for Kids members for the purpose of soliciting members' requests for services. Any activity such as obtaining a list of Medicaid or PeachCare for Kids members or canvassing neighborhoods (or offices) for direct contact with Medicaid or PeachCare for Kids members is prohibited. Any offer or payment of remuneration, whether direct, indirect, overt, covert, in cash or in kind, in return for the referral of a Medicaid or PeachCare for Kids member is also prohibited. It is not the intent of this provision to interfere with the normal pattern of quality medical care that results in follow-up treatment. Direct contact of patients for follow-up visits is not considered solicitation, nor is an acknowledgment that the provider accepts Medicaid/PeachCare for Kids patients.*

801 – Levels of Care

Carepath Level

a) All members are assigned Carepath level I. Indicate if member has intensifying needs for medical monitoring and assistance in the carepath.
b) On the Care Path signature page, indicate if member has functional impairments due to physical disability and / or cognitive impairment. Give Prior Authorization dates, Disease Management information, and signatures as indicated

Note, members will be moved to single care path of Care Path Level I, upon full evaluations starting July 2015

Level of Care Criteria

a) The Intermediate Level of Care (LOC) determination for SOURCE is based on: the medical criteria used by Department of Community Health (DCH), Division of Medicaid to establish an individual's LOC certification for nursing facility placement. SOURCE members must meet the Level of Care criteria for Intermediate Nursing Home Placement (see 801.3). Level of care determination is a function of the assessment process which includes: the SOURCE RN/LPN, using the MDS-HC (v-9), Level of Care criteria (Appendix I), and professional judgment, giving a preliminary determination of Level of Care (LOC) for members during the assessment process.
b) AHS or DCH gives final approval on all members for an active Level of Care.
c) Assessments and re-assessments completed by the LPN must be signed and certified by the designated RN within 10 business days of completion.
d) SOURCE services rendered to a member will be ordered by a physician and listed on the Carepath and Appendix F (level of care and placement instrument). The Primary Care Physician/Medical Director's signature orders the services listed on the Appendix F.
e) Providers may render SOURCE Services only to members with a current LOC as reflected on current SOURCE Level of Care and Placement Instrument (APPENDIX F), approved by AHS (all members as of 9/30/2013), and affirmed by the completed MDS-HC (v9) assessment.
f) Members must meet all SOURCE eligibility criteria to participate in the program.
g) Each qualifying SOURCE member is given an approved LOC certification for SOURCE program participation by AHS. A LOC certification is approved for no more than 12 months (usually 365 days). Members approved for a length of stay less than one year require assessment at least 30 days prior to the expiration of the LOC to re-determine eligibility for the Program.

h) The AHS Prior Authorization effective date is to be the LOS start date on the "Appendix F" LOC form, the AHS expiration date is to be the LOS end date.

i) Effective with SOURCE Initial Assessments conducted on March 1, 2018 or after, the approved length of stay will begin with the day the assessment is conducted. This will allow case management to be covered under a length of stay for a level of care from the date of the assessment. This cannot be billed until the Level of Care has been determined by AHS and attestation of the Medical Director and RN.

Note: DCH maintains oversight of all program components and reserves the right to give final approval on all aspects of the program including eligibility and ILOC. DCH may extend LOC with legal documents or provisional level of care document. This may be especially necessary during the months when transitioning from MMIS locks to Prior Approval system.

801.3 For Source, the eligible individual will meet the target population guidelines and Intermediate Nursing Home LOC:

The target population for SOURCE is physically disabled individuals who are functionally impaired or who have acquired a cognitive loss that results in need of services to assist with the performance of the activities of daily living (ADLs). All individuals must meet the Definition for Intermediate Nursing Home LEVEL OF CARE:

Summary for Intermediate Nursing home LEVEL OF CARE CRITERIA and SOURCE Program guidelines (use to interpret Appendix I):

1. Services may be provided to an individual with a stable medical condition requiring intermittent skilled nursing services under the direction of a licensed physician (Column A Medical Status) AND either a mental/ cognitive (column B) and/or functional impairment that would prevent self-execution of the required nursing care (Column C Functional Status).

2. Special attention should be given to cases where psychiatric treatment is involved. A patient is not considered appropriate for intermediate care services when the primary diagnosis or the primary needs of the patient are psychiatric or related to a developmental disability rather than medical need. This individual must also have medical care needs that meet the criteria for intermediate care facility placement. In some cases, a patient suffering from mental illness may need the type of services which constitute intermediate care because the mental condition is secondary to another more acute medical disorder.

Use the following table to assist with Appendix F and I for SOURCE clients:

To meet an intermediate nursing home level of care the individual must meet item # 1 in Column A AND one other item in Column A, PLUS at least one item from Column B or C (with the exception of #5, Column C)

Items are interpretive guidelines for SOURCE eligibility.

COLUMN A Medical Status	COLUMN B Mental Status (must include a cognitive loss) rev. 04/11 Mental Status impairment with etiologic diagnosis not related to a developmental disability or mental illness The mental status must be such that the cognitive loss is more than occasional forgetfulness	Column C Functional Status impairment with etiologic diagnosis not related to a developmental disability or mental illness
1. Requires monitoring and overall management of a medical condition(s) under the direction of a licensed physician. In addition to the criteria listed immediately above, the	1. Documented short or long-term memory deficits with etiologic diagnosis such that it interferes significantly with the activities of daily living. Cognitive loss must	1. Transfer and locomotion performance of resident requires limited/extensive assistance by staff through help or one-person physical assist.

patient's specific medical condition must require any of the following (2-8), plus one item from Column B or C. 2. Nutritional management; which may include therapeutic diets or maintenance of hydration status. 3. Maintenance and preventive skin care and treatment of skin conditions, such as cuts, abrasions, or healing decubiti. 4. Catheter care such as catheter change and irrigation. 5. Therapy services such as oxygen therapy, physical therapy, speech therapy, occupational therapy (less than five (5) times weekly for SOURCE). 6. Restorative nursing services such as range of motion exercises and bowel and bladder training. 7. Monitoring of vital signs and laboratory studies or weights. 8. Management and administration of medications including injections.	also be addressed on MDS/care plan for continued placement. 2. Documented moderately or severely impaired cognitive skills with etiologic diagnosis as above for daily decision making such that it interferes significantly with the activities of daily living. Cognitive loss addressed on MDS/care plan for continued placement. 3. Problem behavior, i.e., wandering, verbal abuse, physically and/or socially disruptive or inappropriate behavior requiring appropriate supervision or intervention such that it interferes significantly with the activities of daily living. Cognitive loss must also be addressed. 4. Undetermined cognitive patterns which cannot be assessed by a mental status exam, for example, due to aphasia such that it interferes significantly with the activities of daily living. Cognitive loss must also be addressed.	2. Assistance with feeding. Continuous stand-by supervision, encouragement or cueing required and set-up help of meals. 3. Requires direct assistance of another person to maintain continence. 4. Documented communication deficits in making self-understood or understanding others. Deficits must be addressed in medical record with etiologic diagnosis addressed on MDS/care plan for continued placement. 5. Direct stand-by supervision or cueing with one-person physical assistance from staff to complete dressing and personal hygiene. (If this is the only evaluation of care identified, another deficit in functional status is required).

Procedures once '**sl**ot' is available for member:

1) Complete MDS-HC with member
2) Obtain member signature on the SOURCE Level of Care and Placement Form (Appendix F)
3) Forward all material as requested by AHS, to AHS per web portal.
4) IF AHS validates/confirms Level of Care then give the MDS-HC document, placement form and all assessment documents and member information to the multidisciplinary team meeting with the Medical Director (physician) (see section 903 if ILOC is not confirmed).

5) If physician agrees that member meets the definition in section 801.3 including ILOC, physician signs SOURCE Level of Care and Placement Form
6) the agency RN certifies the definition in section 801.3 including ILOC by his/her signature on the SOURCE Level of Care Placement Form

NOTE: Prior to completing the MDS-HC Assessment the RN and/or LPN who conducts or coordinates the assessment process must attend an annual MDS-HC training session scheduled through the Department of Community Health (DCH). Once the MDS-HC assessment is completed by the RN/LPN, the level of care assessment tool can be accessed by an authorized user designated by the SOURCE Site. Should training be needed for new RN's sooner than the annual training, contact the SOURCE Program Specialist.

All SOURCE team members who have access to the MDS-HC System must be an authorized user approved by the Department of Community Health.

802 Primary Medical Care

SOURCE Case Management Provider engages a limited panel of primary care providers who work closely with Case Managers on meeting program and Carepath goals for members. An effective enhanced case management model demands from participating Primary Care Providers a commitment of time, energy and focus. Providers include physicians, (e.g. Internal Medicine, Family Practice and geriatricians), and nurse practitioners.

In addition to traditional functions of evaluation/ treatment for episodic illness and minor injury, key features of SOURCE primary care are:

a) Initial visit upon enrollment, unless member is already under the care of their Primary Care Provider prior to enrollment

b) Chronic disease management, including:

- Risk factor modification and secondary disease prevention
- Monitoring key clinical indicators, including review of data from ancillary services
- Education for members/caregivers about disease treatments, common complications and preventive interventions
- Medication review and management, with current medication list on file
- Referral and authorization for specialists or diagnostic services, as needed
- Coordination of ancillary services

See also Section 1310, Disease State Management.

c) 24-hour a day medical advice/triage

d) Regularly scheduled conferencing between PCP's and CMs

e) Accessibility of PCP to case management staff, as needed

f) Reliance by Primary Care Provider on case management staff for information on:

- Carepath variances
- Home environment
- Informal support
- Community services

g) Case management role includes assisting members in carrying out Primary Care Provider orders and interventions

h) Review by PCP of Carepaths and service plans, upon enrollment and periodically until discharge

i) Referral, coordination and authorization for specialists, hospitalizations, home health and ancillary services, etc.

j) Wellness promotion and preventive health measures, including immunizations, cancer screenings, vision and hearing screening, etc.

803 Site Medical Director

The Site Medical Director occupies a unique position of influence in local perceptions of Community Based Long-Term Care. The Medical Director will ideally have a strong history and connection with the local medical community, facilitating understanding of the model and fostering support for member and program goals. The Medical Director will participate actively on the site's multidisciplinary team and will advocate on behalf of the program or individual member with the local health system or other physicians.

Specific responsibilities of the Medical Director include working with the Multi-disciplinary team to:

a) Advise on the local site's policies/procedures
b) Advise on the local site's internal grievances
c) Advocate on behalf of the program or individual member with the local health system(s), other site physicians or non-participating community physicians
d) Assist with development of and sign Carepath on admission and annually.
e) Confirm the HCBS services ordered, frequency and duration as indicated by the MDS-HC assessment tool, signing the APPENDIX F form for new members, and reassessments, at least annually.
f) Confirm ongoing eligibility for members requiring reassessment to include continuation of level of care eligibility criteria.
g) Review PCP medical record notes at admission, reassessments and with any condition change. Sign Carepath for any changes.
h) Review service delivery issues
i) Review repeated hospital encounters for individual members
j) Review issues of chronic non-compliance
k) Review Carepath variances as requested by case management staff

l) Review discharges to nursing homes.
m) Review utilization data
n) Review complex referrals

804 Case Management

Case Management is a collaborative process which includes assessing, implementing, coordinating, monitoring, evaluating options and services required to meet individual needs and making referrals as needed. SOURCE case managers may consist of nurses, RN and LPN, currently licensed in Georgia and social services workers.

The four components of case management are described as follows:

- Assessment and periodic reassessment – determines service needs, including activities that focus on needs identification, to determine the need for any medical, educational, social, or other services. Assessments are comprehensive in nature and should address all needs of the individual, including an individual's strengths and preferences, and consider the individual's physical and social environment.

- Development and periodic revision of the Carepath – specifies the goals and actions to address the medical, social, educational, and other services needed by the eligible individual, as collected through an assessment or reassessment.

- Referral and related activities – help an individual obtain needed services, including activities that help link eligible individuals with medical, social, educational providers, or other programs and services that are capable of providing needed services to address identified needs.

- Monitoring and follow-up activities – include activities and contacts that are necessary to ensure that the care plan is effectively implemented and adequately addresses the needs of the eligible individual. These activities should take place at least on a quarterly basis for face to face contacts and at least monthly for phone contacts. The monitoring and follow-up activity determines whether the services are being furnished in accordance with the individual's care plan; services are adequate to meet the needs of the individual; and there are changes in the needs or status of the individual.

- Note: The Department of Community Health requires that new SOURCE Case Managers complete training in SOURCE Policies and Procedures within 90 days of employment as well as annually thereafter, as provided by the DCH approved contractor(s).

805 Case Management Supervision

In supporting people with physical and cognitive impairments in living outside of institutions, Case Managers regularly face difficult situations requiring sound judgment and painstaking review of options. To best assist members in maintaining sometimes fragile and complex Carepath plans, Case Managers need active supervisory support. An engaged supervisor will ensure that Case Managers have the benefit of an additional perspective in developing, implementing and adapting responsive Carepaths.

To help meet program and member goals, the case management supervisor's role includes:

a) Regular conferencing to review case management activity around each member and signing SOURCE contact sheets.
b) Availability between supervisory conferences to help Case Managers solve problems around key member issues.
c) Administrative support for Case Managers making significant decisions or recommendations.

The case management supervisor may serve in other program capacities, such as the overall program manager.

Note: The Department of Community Health requires that new SOURCE Case Management Supervisors complete training in SOURCE Policies and Procedures within 90 days of employment as well as annually thereafter, as provided by the DCH approved contractor(s).

806 SOURCE CASE MANAGEMENT TEAM

a. Each SOURCE Enhanced Case Management Team convenes a formal multidisciplinary team meeting at least weekly, to perform the following functions:

Review new admissions and confirm/verify the care path and need for HCBS services, along with service type, frequency and duration
Complete/Review Discharge Planning for new, reassessed and discharged
Authorize service plans for ongoing members
Develop site-specific policies and procedures
Track and analyze repeated hospital encounters for individuals
Hear issues of non-compliance and involuntary discharge
Review chronic Carepath variances and potential nursing home discharges
Review provider or service delivery complications
Review discharges to nursing homes, prior to the date of discharge
Review utilization data
Review complex referrals

Membership on the team may be fluid but will at least include the Medical Director, the program manager, case management supervisory staff, an RN/LPN and case manager presenting new members or information. Other clinical, case management or administrative staff members may participate as needed. At the team meetings, the Medical Director confirms the member meets the definition in 801.3 for a new member**'s initi**al assessment as well as annual re-assessments (or members with a change in level of care) by signature on the member**'s** Carepath and SOURCE Level of Care and Placement Instrument (APPENDIX F) form.

807 Community Services Providers

All community services providers must first be enrolled under CCSP and must comply with CCSP policies and procedures unless indicated otherwise in this manual. As of July 1st, 2013, SOURCE opened enrollment to all current CCSP HCBS providers in good standing. Providers will need to enroll in SOURCE per directions found in section 608. Compliance with increased performance expectations is expected for all SOURCE providers to achieve optimal health states for SOURCE members. SOURCE emphasizes the provider role in achieving outcomes associated with community residence and optimal health status for SOURCE members. This is accomplished by working closely with the Care Management agency and remaining compliant with current policy. When contacted by the SOURCE Case Management Agency and a client is brokered, the provider must abide by all SOURCE rules and conditions, including maintaining current on CCSP policy.

Reimbursed services through SOURCE are:

Personal Support Services/Extended Personal Support (PSS/EPS)
Adult Day Health (ADH)
Home Delivered Meals (HDM)
Alternative Living Services (ALS)
Emergency Response System (ERS)
Home Delivered Services (HDS)
Skilled Nursing Services (SNS) (only used when all other home health agency options have been exhausted, ref. chapter 1900 of CCSP Manual)

Community services primarily offers assistance to members in activities of daily living (ADLs) and instrumental activities of daily living (IADLs). Self-care and informal sources are first maximized before accessing HCBS in SOURCE. The Community Care Services Program provider manuals may be referenced for definitions of these service categories. Unless otherwise noted in this document, Community service providers will operate in accordance with CCSP provider-specific manuals. Copies of CCSP provider-specific manuals are available through the DXC Website: www.mmis.georgia.gov

Key characteristics of the SOURCE provider role (and used for provider compliance):

a) Intensified communication/coordination with case management staff, over conventional HCBS programs
b) Commitment to continued service for members with challenging personal situations or diagnoses
c) Demonstrated efforts to serve manpower shortage areas
d) Service for members needing PSS/EPS hours both above traditional service levels and below
e) Willingness to flex service levels as authorized by Case Manager, in response to the complex or unpredictable status of individual members
f) Customer satisfaction standards exceeding basic licensing requirements; specific areas of accountability include:

Reliability of service, including early morning or late evening visits

Competency, compatibility and consistency of staffing

Responsiveness to member and staff concerns, including the scope of care as described by the member or caregiver

Coordination with Case Manager

g) Regular measurement of performance
h) Monthly utilization and reconciliation reports of all providers
i) Carepath measurement of customer/site satisfaction with services every quarter
j) Complaint Log for PSS/EPS providers* (may use for other providers as desires)
k) Internal Care Coordination Complaint log will be maintained for all providers
l) Complaint log will be maintained for the program
m) An active 24-hour on-call service that coordinates dependably with Case Manager and members/Caregiver

(*Applicable only to PSS/EPS providers, the service category most heavily utilized by SOURCE members.)

901. SCREENING

Potential SOURCE members will be screened to determine likely eligibility using the Determination of Need – Revised (DON-R) screening tool. The tool was designed and validated for use in telephonic screening and provides a method for prioritizing SOURCE applicants for admission. SOURCE screening is performed by the SOURCE Enhanced Case Management agencies, usually at the time of applicant inquiry by telephone. Screening is conducted by phone or can be conducted face to face in the case of difficult to screen individuals (those with communication impairment, no telephone, or cognitive impairment). Referrals may come from many sources, including but not limited to:

a) Hospital discharge planners
b) Physician offices
c) Family members or other informal caregivers
d) Community social service agencies
e) Home health agencies or other health system organizations

Procedures:

a) Inquiries will be documented using the DON-R tool along with the SOURCE screening form used for collection of demographic data (Appendix C).

b) Medicaid Eligibility: Screening staff will access the GAMMIS website to confirm a potential member's eligibility status. For persons not eligible for SOURCE or not interested in joining the program, appropriate referrals to other services or organizations will be made (including referral to the Social Security Administration if the person screened may be eligible for SSI). See also Policy No. 1405, Right to Appeal.

c) Functional Eligibility: Full screening is completed within three business days of the initial inquiry. Extenuating circumstances which prevent meeting the standard of promptness will be documented on the screening form (Appendix A). All telephone screening is only considered complete when performed using the Determination of Need – Revised assessment tool attached at Appendix KK.

d) Depending upon availability of SOURCE benefit funds, applicants who have been telephone screened and determined eligible for the Program may have to be placed on a waiting list for full assessment. When placed on a waiting list, an applicant will be advised of his right to be re-screened if his functional need or status changes. In the absence of applicant-initiated contact, applicants will be rescreened by the SOURCE EPCCM agency that conducted the first screening using telephone contact and re-administration of the DON-R every 120 days if held on the waiting list.

e) In the case of wait lists for SOURCE admission, the EPCCM Agency sends the completed DON-R with legible demographic information to the DCH Program Specialist via facsimile or use of the www.source.dch.ga.gov e-mail address via secure method of transmission.

f) For those meeting SOURCE Medicaid eligibility criteria and wishing to pursue enrollment, information gathered from the screening will be used to determine admission priority and returned to the submitting EPCCM Agency to schedule assessment as program slots are available. In the case of a waiting list, those with the highest level of need as identified through use of the DON-R are admitted to the SOURCE Program.

902. ASSESSMENT

All persons who meet screening requirements for SOURCE, and program slots are available will be formally assessed in their homes by the EPCCM RN/LPN (exceptions noted below) prior to initiation of services, using the MDS-HC (v9) and other SOURCE approved Assessment Tools. The purposes of assessments are:

a) Evaluation of the member's medical and health status; functional ability; social, emotional and environmental factors related to illness, and support system, formal and informal, Level of Care determination, Carepath development and delivery of community services.

b) Identification of urgent problems which require prompt attention.

c) Gather data regarding the population served by the program, for Division of Medicaid review and to develop protocols for care.

d) Evaluate the member's home environment (assessing the physical structure and home safety, meeting caregivers or family members as indicated to assess informal support system, etc.). See Section 1005, Self-Care and Informal Support.

Exceptions to member "in home" assessment

a) Member is receiving in-patient care in an acute care facility awaiting discharge to a community-based environment

b) Member is currently residing in a nursing home

Procedures:

a) Following screening and slot allocations, within 5 business days, the case management staff schedules the initial assessment. The Initial assessment will be completed within 10 business days.
b) A Case Manager or a nurse may complete the Assessment Addendum Form;

c) Nurses will assess all potential members using the MDS-HC (v9) assessment tool and determine eligibility for the Program based on ILOC criteria and need for community-based services.
d) When the MDS-HC is completed by an LPN, within ten (10) business days from the date of the assessment, the RN reviews the MDS-HC, completes and signs Appendix T to indicate supervisory review.
e) Appendix T is a signature page that confirms all who are present and assisted in interview for the MDS-HC and that the MDS-HC received RN review and agreement. It must be signed within 10 business days of the MDS HC assessment by the RN. It is part of the member assessment. The Appendix T will be uploaded to AHS with the assessment packet.
f) Applicants who meet ILOC but have all needs met by informal supporters are not appropriate for admission to SOURCE.
g) Assessments will take place in the home of the potential member, unless enrollment is necessary prior to discharge from a hospital, nursing home or rehabilitation facility.
h) A caregiver, family member or advocate shall be present whenever possible during assessments for members with:
(1) A legally appointed guardian
(2) A known diagnosis of Alzheimer's or dementia
(3) Other known significant cognitive or psychiatric conditions
Note: Individuals who are wards under legal guardianship procedures may not enroll themselves in the SOURCE Program nor sign program-related documents

i) While an informal caregiver may assist with answering assessment questions as needed (see above in particular), the potential new member is the primary source of information whenever possible and is interviewed in person.

j) The Case Manager or nurse will review the program's operations with the potential member following the assessment, including selection of the site as Preferred SOURCE agency.

k) The following forms will be reviewed with the SOURCE member and signed (see Appendices).

SOURCE Rights and Responsibilities, obtaining signatures on two copies (one left with the member, one for filing in the administrative chart) and including information on a member's right to appeal decisions of the site, signed at admission and at reassessment, at least annually.

Consent for Enrollment form signed at admission.

Records Release Authorization signed at admission and at reassessment, at least annually.

SOURCE Level of Care and Placement form, formally selecting SOURCE as Case Management Agency under Medicaid at admission and level of care status.

l) The Case Manager will provide the member/caregiver with the names of participating Primary Care Providers. All members enrolling must select and agree to use a designated Primary Care Provider.

m) All new members, not currently an established patient of a SOURCE physician must have an initial visit with the program Primary Care Provider selected. The member/informal caregiver OR the Case Manager may schedule the initial visit.

n) The assessment process will be initiated within 5 business days of release from wait list for members who must go through the wait list process. In situations where the standard of promptness is unmet, justification for failure to meet standard will be documented in the case notes of the member file.

o) The Case Manager must include directions to the member's home starting from the local SOURCE Enhanced Case Management office to member's home address.

p) Following completion of the admission assessment, the Case Manager will record all recommended services on the Services Recommended Form.

q) Case Manager will request and record member feedback and signatures from both member and Case Manager will be secured.

903. Program Admission Procedures

SOURCE admission occurs with these steps following assessment:

1. Initial determination of eligibility using the definition in section 801.3 as recommended by the assessment nurse using the information gathered from the MDS-HC (v9) and compared to the Level of Care Criteria (Appendix I)
2. Submitting the assessment packet to Alliant Health Solutions (AHS), the Division of Medicaid's medical management vendor, for validation of level of care.
3. Prepare information on Community Supports available to member that may be used to support the member during their stay in SOURCE or information that can be used to support member at termination. Prepare for Discharge at the time of enrollment.
4. Receive confirmation of the level of care approval from AHS.
5. Review new/reassessed members by a multidisciplinary team.
6. Prepare Carepath. Admission is considered complete upon the MD order/signature on the Level of Care and Placement Instrument (Appendix F) which provides the physician order for HCBS services, confirms LOC, and RN signature for certification of level of care. Carepath completion is required within fourteen (14) days of this date

7. Upon completion of enrollment (synonymous with the PA approval/effective date) and initiation

Provide the following completed documents to all community service providers:

- MDS-HC and MDS-HC signature page (Appendix T) with RN signature and date
- SOURCE Level of Care and Placement Instrument (Appendix F); must contain required signatures (physician and RN) and date of signatures
- Level of Care Justification (Appendix I)
- The Source Carepath
- Member version of carepath
- Rights and Responsibilities
- Member Referral Form
- Member Information Form, if applicable
- Advance Directives (See Section 903, Procedure (j)
- Directions to the member's home, starting from the local SOURCE site to the member's home address (See Section 902, Procedures (k)

Prior Authorization numbers (may put on transfer, Carepath, or App F

Rev. 04/11 Note: All services ordered must be listed on Appendix F. The exception to this is if the member is not due for a reevaluation and the new service ordered does not require a reevaluation/ reassessment; in the case of new services ordered without full reassessment, the services are added on the Carepath and indicated as ordered by physician by signature and date on the Carepath.

B. Provide the following completed documents to the member:

- Member participation form
- Carepath-Member Version

NOTE: Assessment packets are submitted only through the secure AHS web portal for review. All correspondence related to admissions will be conducted through the secure web portal.

Documents to be submitted via web portal include:

Appendix F: Level of Care and placement Form (filled out in entirety)
Appendix I: LOC justification for Intermediate Nursing Facility Care
MDS-HC form and the Appendix T with RN signature
Medication Record Form (Appendix SS)
Case Notes (6 mon of Case notes for reassessment including Appendix U)
DON-R Screening Tool for initial assessments only
AHS may request additional information if needed for confirmation of diagnosis or care level (ie dementia diagnosis that is not supported by documentation or suggestive of mental health issues.

Process for Routine admissions:

For HCBS provider billing, SOURCE members are enrolled in the program after Prior Authorization LOC approval is given by AHS. The Prior Authorization effective date is considered the date of AHS approval and serves as the date of SOURCE lock in. However, services may not be reimbursed until the

SOURCE physician signature authorizes approval of the HCBS services including enhanced case management. The R.N. signs the ILOC form after concurrence is provided by AHS or DCH review.

Process for members who meet eligibility:

Eligibility requires AHS approval for any initial SOURCE clients or SOURCE member reassessments on or after 9/30/2013. Services may not be delivered until a AHS approval and a valid Appendix F ordering HCBS services is in place.

Routine Admission Overview:

The Case Management Agency makes an appointment with the member for a face to face interview.
The Case Manager may complete the Assessment Addendum (optional)
A nurse completes the MDS HC.
When the MDS-HC is completed by an LPN, within ten (10) business days from the date of the assessment, the RN reviews the MDS-HC, completes and signs Appendix T to indicate supervisory review.
Appendix T is a signature page that confirms all who are present and assisted in interview for the MDS-HC and that the MDS-HC received RN review and agreement. It must be signed within 10 business days of the MDS HC assessment by the RN. It is part of the member assessment.
Upon completion of enrollment and initiation of services, case manager will provide the following completed documents to all community service providers:

- MDS-HC and MDS-HC signature page (Appendix T) with RN signature and date
- SOURCE Level of Care and Placement Instrument (Appendix F); must contain required signatures (physician and RN) and date of signatures
- Level of Care Justification (Appendix I)
- The Source Carepath
- Member version of carepath
- Rights and Responsibilities
- Member Referral Form
- Member Information Form, if applicable
- Advance Directives (See Section 903, Procedure (j)
- Directions to the member's home, starting from the local SOURCE site to the member's home address (See Section 902, Procedures (k)

All sites shall maintain in the front of each chart for each active member a current Face Sheet with basic demographic information, to include at least the following:

- Name
- Date of Birth
- Address/Phone
- Male/Female
- Medicare/Medicaid or SSN numbers
- Directions to member's home

- Responsible party information (phone, address) if applicable
- Emergency contact information (phone, address)
- SOURCE PCP
- SOURCE Case Manager
- Date of SOURCE enrollment
- Diagnosis
- Advance Directives- Yes/No
- Discharge date

Case managers will provide the following completed documents to the member:

- Member Participation form
- Carepath-Member Version

The Case Manager submits documentation via the web portal to AHS. Exceptions, if the member has a current Prior Authorization that is not expiring within 3 months, it is not necessary to submit to AHS. AHS reviews the assessment package and confirms Level of Care.
Documents to be submitted via web portal include:

- Appendix F: Level of Care and placement Form (filled out in entirety)
- Appendix I: LOC justification for Intermediate Nursing Facility Care
- MDS-HC form and the Appendix T with RN signature
- Medication Record Form (Appendix SS)
- Case Notes (6 months of Case notes for reassessment including Appendix U)
- DON-R Screening Tool for initial assessments only
- AHS may request additional information if needed for confirmation of diagnosis or care level (ie dementia diagnosis that is not supported by documentation or suggestive of mental health issues).

Following level of care approval by AHS, the member assessment and care path recommendations are to be reviewed by the multidisciplinary team.

Case Managers will use the following format in presenting newly eligible members to the weekly admissions meeting of the multidisciplinary team:

(1.) Member name, age and diagnoses
(2.) Caregiver information, if applicable
(3.) ADL/IADL impairments from MDS-HC Assessment
(4.) Current medications
(5.) SOURCE physician selected from panel
(6.) Factors complicating Carepath planning (lack of support, recent hospitalization, etc.)
(7.) Recommended SOURCE services
(8.) Other community services planned or in place

(9.) ADH level recommended

ADH LEVEL I. Client Profile:

1. Requires watchful oversight to ensure safety and/or
2. Requires medical monitoring on a weekly basis or more often.
3. Requires minimal to maximal assistance with activities of daily living (Refer to Section 1103.4C for a list of tasks).
4. May require assistance with self-care or verbal cues to perform self-care (e.g. safely entering and existing a shower or assistance with toileting).

ADH LEVEL 2. Client Profile:

1. Oversight needs to ensure safety.
2. Medical monitoring needs.
3. Level of Need for assistance with personal care such as transfers, ambulation, bathing, or eating.
4. Any Need for specialized therapy.
5. Need for specialized nursing services such as bowel or bladder retraining, catheter care, dressing changes, or complex medication management.
6. Disease Management Needs (if required due to poor outcomes on medical parameters and/ or variances

The team reviews information to ensure that:

(1.) Informal support is analyzed and maximized
(2.) Services recommended are logical and cost effective
(3.) Key health status issues are identified, with urgent problems addressed

Following discussion of information presented, the multidisciplinary team reviews the Level of Care, MDS HC and other SOURCE approved assessment tools for development of the care path and service plan.

The Medical Director and/or member's primary care physician confirms that the member meets eligibility requirements for the SOURCE Program and orders specific services on the SOURCE Level of Care and Placement Instrument (Appendix F) by signature. His/her signature on the Carepath confirms the service level. Medical Director or PCP must sign the Level of Care Placement form within 90 calendar days of the member signature.

Once the physician signature is on the level of care form, then a Service Prior Authorization can be created in the Medicaid information System.

If applicable, the team also assigns the ADH level of service.

AHS communicates level of care approvals to DCH weekly for admission.

Ineligible members

Ineligible Initial Clients (New Clients)

Process for new clients who do not meet admission criteria due to incomplete information / application (technical denial)

- AHS does not validate/does not confirm Level of Care and eligibility
- AHS sends out a certified letter to the member (uses the address listed in the MMIS)
- AHS notifies by email and sends a letter to the SOURCE agency
- The SOURCE agency notifies the member and makes sure any questions are answered
- The agency Medical Director and R.N. DOES NOT sign Appendix F, Level of Care
- SOURCE Agency reviews the discharge plan with community supports, adding information as needed, giving it to member when complete (See Discharge Appendix BB and Z7)
- The SOURCE Case Manager follows the instructions on Appendix Z8 and ensures completion
- Denial for an incomplete application will only be communicated if the SOURCE agency fails to submit the require information to AHS for review.

Process for established members who do not meet continued eligibility at reassessment

- If a member no longer meets Level of Care (and does not appeal) or is discharged for any other reason, the site will notify all service providers and end all lines on the service Prior Authorization.
- Except in cases where member meets immediate discharge criteria (i.e. threatening behavior),
- the agency should attempt to determine if the member is going to appeal and give the member 30 days before ending the service Prior Authorization.
- Service Prior Authorizations should be ended in 30 days by the Case Management agency if member has not appealed.
- The appropriate forms should be placed in the member's chart.
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904 Routine Reevaluations/ Reassessments (Complete Re Evaluation Packets)

Source members are evaluated for continued eligibility at least annually, and more often as necessary as directed by AHS, or as directed by DCH. Re-evaluations are to be completed by a licensed nurse (currently licensed in the state of Georgia). Re-evaluations completed by an LPN must be reviewed and approved by a supervising RN. Reevaluations are sent to AHS to obtain approval. The SOURCE case management agency confirms that the member continues to meet criteria for:

- Eligibility using the definition in section 801.3 including Intermediate Level of Care for nursing home placement.
- Continued eligibility, appropriateness, and need for SOURCE services
- Allows for adjustment of the CarePath goals and service planNote: All services ordered for member at the time of reevaluation must be listed on Appendix F, Line 23

1. Schedule face to face with member and review with member/member representative all documents

2. Complete MDS-HC (v9) Assessment

3. Complete SOURCE Level of Care Placement Instrument (Appendix F)

4. Discuss with member continued eligibility or if indicated possible ineligibility

5. Initiate the development of a new CarePath with the member/representative

6. Obtain AHS approval on all annual reassessments with MDS

7. Present member information and documentation at multi-disciplinary team meeting
Complete certification of LOC and continued participation in SOURCE

8. Complete certification of LOC and continued participation in SOURCE

9. Provide copies of reassessment documents to community service providers before LOC certification end date. The following documents are maintained as part of the SOURCE member clinical record:

- The MDS-HC, Source Assessment Addendum, and MDS-HC signature page (Appendix T), with RN signature and date
- SOURCE Level of Care and Placement Instrument (Appendix F), with required signature (s) and date (s)
- Level of Care Justification (Appendix I)
- The SOURCE Carepath
- Member Version of the Carepath
- Member Referral Form
- Member Information Form (if applicable)
- Rights and Responsibilities
- Advance Directive (See Section 903, Procedure (j)
- Directions to the member's home, starting from the local SOURCE site to the member's home address (See Section902, Procedures (k)

10. If member is not approved for SOURCE during the Reevaluation/Reassessment process, and the member appeals, a copy of the AHS notice of appeal or the member's copy of DCH Legal Services Division acceptance of member's appeal, will extend the LOC currently in place

NOTE: If members no longer meet eligibility criteria for SOURCE participation refer to Section 1405 and 1406 of this manual.

905 Modified Reevaluation/ Readmission into SOURCE

Modified Reevaluation Process may be used for members with Current PA greater than 3 months from expiration. Such as:

- Members returning to SOURCE from Nursing Home
- Memer returning to SOURCE from a Prolonged Institutional Stay
- Internal or External Case Management Agency transfer or
- Member has changes in functioning that significantly affects how care is delivered

This policy is for Medicaid members who have an active SOURCE Prior Authorization. That authorization must have an expiration date greater than 3 months or more into the future. This may be used for

members who have been in Nursing Homes or have had hospital stays. Inappropriate use would be for members who have improved in their health and can care for self. Interview of member for this process may be conducted by LPN or RN.

Procedure:

Using the: Modified Reevaluation Contact Sheet for Members with Active Prior Authorizations (Appendix QQ).

1. LPN/RN completes the Modified Reassessment form (Appendix QQ) with the Member/Representative.
2. Review and update CarePath to include any changes noted in care needs or need for Disease Management or member/representative education.
3. Complete an Appendix E if there is a change in the physician orders needing signature.
4. If this is due to a transfer, be sure the Transfer Form (Appendix X) is complete from the agency that transferred to receiving agency and it has been sent to AHS for LOC PA transfer. Complete an Appendix D and Appendix E for transfers.
5. Send the DMA 59 to DCH if member was discharged from a nursing home to restore SSI.

RN reviews and Signs MODIFIED RE EVALUATION CONTACT SHEET FOR MEMBERS WITH ACTIVE PRIOR AUTHORIZATIONS/APPROVALS RN supervisory review indicates that medications and treatments are consistent with diagnosis and appropriate to be given at home. RN documents recommendation for home care, educational needs, and disease management on the CarePath. If a Sentinel event led to this Nursing Home admission, RN reviews the Sentinel, documents recommendations under action plan and/or process improvement and signs/dates the form. All urgent Information is directly communicated to Case Management staff and documented. The RN signs the appendix F after being signed by the Medical Director.

Case Management and Case Management Supervisors: Assure that all documents are completed. Assure Care path is updated. Assure resources are in place for a smooth, safe transition home.

Review member during Team and Quarterly Case Management meetings. Assure that urgent needs were addressed. Update any Sentinel Event that lead to this admission under action plan and process improvement (with new dates and data). Resend Sentinel to DCH with UPDATE written on top.

Procedure for Community Service Providers:

COMMUNITY SERVICE PROVIDERS should receive this information for readmissions:

Source Modified Re-evaluation Contact Sheet
Current active Appendix F
Source Updated Care Path with current dates;
Member Version of Care Path;
APPENDIX D Rights and Responsibilities; Consent for reenrollment
APPENDIX W Member Information Form;
ADVANCE DIRECTIVES (if not previously acquired);

If this is a new transfer in, include the MDS-HC and Appendix F sent by the sending agency.

906 SOURCE Member Transfers (Internal and External):

SOURCE members may transfer to another SOURCE site within the same company (Internal transfer) or to another SOURCE agency, CCSP agency, ICWP agency, or NOW/COMP (External transfer) and remain eligible for the Elderly and Disabled Waiver.

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Upon notification of a transfer to your agency or leaving your agency, contact the member or member representative to verify informed choice of the transfer and date of transfer.

Discharging/Transferring Agency:

1. With a current LOC PA, Complete the Universal Waiver Transfer Form (Appendix X), to include the last date of service, and upload to Contact Us on MMIS to request the transfer of LOC.
2. Notify the AAA for the CCSP agency with demographic information to create a chart in Harmony if applicable.
3. Send to receiving agency one year of documentation to include the most current MDS, Case Notes, Medication List, and Appendix F. DO NOT obtain the Medical Director's signature on the Appendix F to discharge waivered services when a member is discharged with a current LOC PA. Current Appendix F is used to broker services with the receiving agency and is good until the LOC expires.
4. Notify HCBS providers of the last day of service for the discharging/transferring agency.
5. Ensure all lines on the service PA have ended.

Receiving Agency:

1. LPN/RN will complete a home visit contact and complete the Modified Evaluation, discuss services, and review and revise the CarePath if needed.
2. If the Appendix has been discharged the receiving agency will obtain a current order for services signed by the MD RN.
3. If the LOC is expiring within the next 60 days, the nurse will do the entire MDS and packet and submit to AHS for approval. Contact DCH to request it be expedited through AHS.

Transfers from SOURCE to CCSP no longer require care to begin on day one of the next month. Transfers can now occur on days other than the end of the month. The discharge date from one to the other must be agreed upon in advance so the worker can end date the services PA before the new services can begin. The two service PAs cannot overlap. The area the member is leaving (Discharging/Transferring Agency) will bill for the month the transfer occurs. The Receiving Agency will bill the following month and ongoing after the transfer took place.

1001. Carepaths

SOURCE utilizes Carepaths as a standardized set of goals with expected outcomes, to develop a plan of care for SOURCE members. Carepaths, designed around indicators associated with chronic illness and impairment, are individualized plans written and implemented for each member. Carepaths, while not disease-specific, address risk factors held in common by people at the SOURCE Nursing Home Level of Care. The SOURCE Assessment nurse, with input from the case manager, is responsible for development of the member carepath at initial assessment and at each re-evaluation.

Members and informal caregivers, service providers, Primary Care Provider staff, RN's/LPN's and Case Managers, together, implement the Carepath, adjusting the plan when necessary to meet key outcomes and goals.

The program uses Carepaths to:

a) Standardize case management practices
b) Identify roles for specific players
c) Identify gaps in self-care/informal support, creating a framework for paid SOURCE services
d) Target and analyze problem areas for individual members and across the entire program

SOURCE promotes member independence, self-care and assistance from informal care givers. When appropriate, the case manager may coordinate education or training for members or informal care givers to teach direct care, patient education, and monitoring of chronic conditions. Self-Care and informal support are reflected in the development and implementation of each carepath. At minimum, the member Carepath will address the following:

- Community residence (related to care path outcomes ie. keeping medical appointments, member satisfaction with services
- Nutrition/weight
- Skin care
- Key clinical indicators (blood pressure, blood sugar, weight monitoring and lab studies)
- Medication compliance
- Performance of ADLs and IADLs
- Transfers and mobility
- Problem behavior (s), if applicable
- Informal care giver support

Carepath addendums are available for care planning to meet housing goals/ outcomes to address incontinence issues. These additional care planning tools can be used with all members regardless of care path level. Agencies are to create their disease management profiles to meet member's needs.

1002 Carepath Development and Completion

Carepath development requires that the CM/LPN/RN use information gathered from many sources to produce and maintain a consensus between members/caregivers and Primary Care Providers to meet individual and program goals. The Source assessment nurse and case manager will evaluate the member's need for assistance with performance of his/her activities of daily living and instrumental activities of daily living, monitoring of chronic medical conditions and other areas which impact the member's ability to continue living in the community. Evaluation begins with the referral and screening process through the initial assessment and continues for the duration of the member's length of stay in the program. Assessment nurses and case managers will:

- Determine member formal and informal support, availability and reliability (Whenever possible, nurses/CM's will meet with informal caregivers to discuss care planning)
- Add to SOURCE Carepath profiles when information is obtained from the member/family during the assessment
- Effective date and expiration date of the Carepath will be taken from the Prior Authorization dates given by AHS.
- A new Effective date that services were restarted may be documented by a Case Management agency on the carepath if service is interrupted during an active Prior Authorization.
- Short term hospitalizations (less than 2 weeks), temporary moves, member initiated internal transfers, member need for different services, may be documented with a Carepath update and case note. Document service change on the Carepath with Physician Signatures
- A prolonged Span for hospitalization, nursing home stay, rehab stay, may meet requirements for a modified reevaluation. See section 905 Modified Reevaluation/ Re-admission into SOURCE
- Prior Authorization expiration dates are only given by AHS
- Complete the Carepath within fourteen (14) days of the completion of the enrollment process which includes determination of level of care, physician signature, and is finalized by the RN signature. Present the Carepath at the Inter-Disciplinary Team (the Medical Director reviews the completed Carepath, recommends changes, as needed, and signs indicating approval). sign the cover page of the carepath with the date the carepath is completed
- Case management or Physician may add or delete services (with explanation) for the member on the carepath. Physician must indicate approval with signature and date.

See instructions for completing the Carepath document at the end of Chapter 1000.

NOTE: When a new service is required as the result of a change in member support or functional capacity; the physician signature and date on the Carepath will confirm his or her review and approval of the new plan of care.

1003 Completed Carepaths

Completed SOURCE Carepaths will have understanding and agreement from the member/care giver and the Medical Director. The Case Manager will formally review the carepath goals every quarter.

Initial review of the carepath with the member confirms that:

- member understands expected outcomes
- plan accurately describes self-care capacity and informal resources
- reimbursed services are offered at the appropriate level
- Information on community services that will enhance member's wellbeing are provided as available and included on Care Path.

Case managers will review carepath goals during regularly scheduled contacts with the member to ensure that the plan is current and continues to support the member's ability to remain in the community

During the initial review of the individualized member carepath with the Medical Director, the following exchange of information will occur:

- PCP role in patient education and treatment from obtained medical records
- monitoring of chronic conditions at home
- self-care capacity/informal supports identified
- reimbursed services ordered

CM documents in case notes medical director's recommendations. Bi-annual PCP conferences will include review of variances of the carepath goals.

Service provider review of Carepath allows provider agencies to:

- confirm the authorized service levels
- understand and acknowledge service provider role in supporting member carepath goals
- understand the member and caregiver role (s) in meeting carepath goals

Carepaths are discussed with provider on new enrollment/reassessments and with changes during provider meetings to ensure provider awareness of their role. MIF, referral, or other documented communication will be amended by the case notes as indicated to reflect changes in the carepath

During regular monthly case management supervision conference, the SOURCE case management supervisor will review and sign completed carepaths for new members, reassessed members or those members with Carepath level changes.

1004. Carepath Formal Review

Case Managers formally review Carepaths with members and with Primary Care Providers. Based on Case Manager's observation and information received from members or caregivers, Primary Care Providers, providers and/or other parties involved, goals are recorded as "met" or "not met." For all members, every goal that is not met requires corrective action by the Case Manager (see Policies III A-E, Concurrent Review and Policy II F, Carepath Variances).

1005. Member Version

Each SOURCE Carepath is accompanied by an abbreviated Member Version that lists desired outcomes and the plan for achieving them. The member version includes formal/informal support caregivers. The document serves as an educational tool for members/informal caregivers throughout their participation in

SOURCE. Case Manager/LPN/RN will complete the member version carepath within (14) days of completion of the enrollment process.

Upon on a new member's admission, the Member Version will be faxed or mailed with the referral information to the service provider along with all other documentation as specified in 1401.

The member version carepath is reviewed with the newly admitted member at the first face-to-face visit. During that visit, the member signs this version, acknowledging understanding and agreement. Case manager signs to indicate explanation of the document and its contents.

Instructions for completion of Carepath document:

1. Complete member name and the effective date of the carepath. Effective date of the Carepath is the effective date of the PA.
2. Complete each page of the carepath by documenting which tasks will be performed
3. Document the name of the individual responsible for performance of the task in the "responsible party" section
4. Additional information for meeting goals is documented in the "Notes" section found on each page
5. For issue specific goals, outside the scope of the carepath; CM will fully document the goals, plan and responsible party, using the final page of the care path document. Additional goals, outside the established Carepath outcomes must be approved by the Case Management supervisor, by signature and date. Each outcome/goal must be reviewed and progress documented at quarterly intervals

When utilizing an additional carepath such as incontinence (Appendix R), the case manager or assessment nurse determines the need for its use and creates a plan. The effective date for an additional carepath is the date that the CM or nurse is adding the addendum.

Changes in the carepath must be documented in the Case Manager's notes and on the Carepath document by drawing a single line through the previous entry with CM/nurse initials and date.

1100 Reimbursed Services

To implement the Carepath, the Case Manager will refer the new member for reimbursed services, if applicable. Information provided to the agency must be sufficient to allow for effective service delivery and accurate billing.

Procedures:

a) The member will choose their providers from active provider list and it will be written on the Appendix C1 with signature of member and case manager.

b) Due to the complexity of care involved, Case Managers will discuss new referrals by phone or in person, for the following service categories:

(1) Personal support/extended personal support
(2) Adult Day Health
(3) Alternative Living Services
(4) Home Delivered Services

d) Home delivered meals and emergency response system referrals will not require a phone call prior to making the referral in writing.

e) The Case Manager will complete the SOURCE Referral Form.

f) In addition to demographic information, the Referral Form must include specific units of service requested and the Authorization Number.

g) Additional information pertinent to service delivery for an individual member will be noted in the “Comments” section at the end of the Referral Form.

h) All providers will also receive copies of the following which are maintained as part of the SOURCE member clinical record:

- The MDS-HC, SOURCE Assessment Addendum, and MDS-HC signature page (Appendix T)
- SOURCE Level of Care and Placement Instrument (Appendix F)
- Level of Care Justification (Appendix I)
- The SOURCE Carepath
- Member Version Carepath (unsigned version maybe sent initially, CM must send signed version within 10 days of signature procurement)
- Rights and Responsibilities

i) Providers will send the Case Manager a Member Information Form confirming the service level and the date services will begin.

j) If the Member Information Form does not match the Initial Referral Form, the Case Manager will call the provider to clarify the referral.

k) Changes in paid assistance will be documented in the Case Manager's notes and on the Carepath, by drawing a single line through the earlier Carepath entry, and initialing and dating the current entry. See also Section 1405, Right to Appeal (regarding decreasing or terminating services)

(1) The Case Manager will confirm the appropriate service level by assessment to determine that a

different level is required to meet Carepath goals.

(2) The Case Manager will review the recommended service change(s) with his/her supervisor.

(3) If the supervisor approves the change, the Case Manager will authorize the new service level in writing, by completing the Member Information Form and sending a copy to applicable providers.

(4) The original Member Information Form is filed in the member's chart.

(5) The Case Manager will amend the Carepath and the Member Version as indicated, forwarding an updated copy to the member/caregiver and the Primary Care Provider

NOTE: Member Information Forms (Appendix W) are acknowledged, in writing by the receiving agency and returned to the initiating agency within three (3) business days.

l) Changes in paid assistance will be documented in the Case Manager's notes and on the Carepath, by drawing a single line through the earlier Carepath entry and initialing and dating the current entry. See also Section 1405, Right to Appeal (regarding decreasing or terminating services)

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1200.Carepath Variances

Simply stated, a variance is when an expected outcome doesn't occur. In SOURCE, a variance describes a Carepath goal not met by a member at any point during a quarterly review period. For any goal not met, corrective action by the Case Manager is required. The Case Manager will act quickly to help members resolve variances, to prevent further complications that may jeopardize health or functional status.

Procedures:

a) Case Manager will identify the variance, recognizing problematic issues as goals not met and uncovering the source(s) of the problem.

b) Case Manager will act to resolve the variance. Specific steps taken will depend on the member's individual circumstances, and on which goal was not met and why. Examples of corrective action may include:

- Arranging patient education for the member or informal caregiver
- Scheduling an appointment with Primary Care Provider
- Increasing service levels or changing service categories
- Coordinating with provider on service delivery issues

c) The Case Manager will document all variances appropriately:

(1) The Case Manager will indicate "not met" in the Carepath quarterly review column for that goal.

(2) The Case Manager will complete a Variance Report form to indicate the source of the variance and specific corrective actions taken.

(3) If the variance was discovered or noted before the quarterly home visit, the Case Manager will also indicate the variance on the Contact Sheet in the Monthly Contact section as applicable.

(4) If the variance was discovered or noted at the quarterly review home visit, indicate the variance on the Contact Sheet Quarterly Review section.

(5) If the variance was discovered at the Primary Care Provider conference, indicate the variance on the Contact Sheet Primary Care Provider conference section.

d) The Case Manager will further document corrective actions in the member's case notes, on the Member Information Form to providers approving service level changes, on the Carepath if a change to the plan was made, etc., as applicable.

e) The Case Manager will discuss and document variances with the PCP on the bi-annual contact form and other service providers as applicable

f) For variances repeating for a second quarter or longer, the Case Manager – in conjunction with the case management supervisor or program administrator– will increase efforts and resources employed to resolve the variance.

1300. Concurrent Review

Communication is key to the SOURCE concept of integration. Defined formally in the program as concurrent review, there are four fundamental principles to SOURCE communication:

- Preventive efforts will be effective and current
- Problems will be quickly identified
- Action will be promptly taken by the appropriate parties to resolve problems
- Resources will be appropriately targeted for maximum results and cost efficiency

Case Managers and Carepaths are at the core of concurrent review in SOURCE. To reach the program's stated goals, Case Managers initiate and facilitate communication with SOURCE members/caregivers, Primary Care Providers, program supervisors, and if applicable, providers; Carepaths provide guidance and formal structure for the concurrent review process.

All key players in SOURCE may possess information on the member's current condition and on Carepath variances; however, with increased contact, familiarity or specific skills, each contributes unique perspectives as well:

Members/CG:	current condition (primarily self-report); preferences; capabilities; household dynamics/informal support
Primary Care Providers:	clinical condition, recommended treatments and compliance; information from diagnostic procedures, specialist visits, etc.
Providers:	current condition as observed by trained staff; household dynamics/informal support as observed externally

In addition to the program's key players, concurrent review includes other entities as appropriate, on an individual basis (example: dialysis center patients) or for a limited time (example: hospitalizations).

The job of the Case Manager and his or her supervisor is to analyze and use all information received to help the SOURCE member stay as healthy as possible and to meet Carepath goals.

Communication with key players falls into two categories: scheduled or PRN (as needed in response to recognized triggers). Scheduled contacts serve as an overview for key players, an opportunity to spot patterns or trends and respond preventively. PRN contacts more typically address individual issues as they arise.

1301. Scheduled Contacts with Members

The Case Manager will regularly initiate contact with the members/caregivers and will make follow up contacts as needed with providers, Primary Care Providers, etc., on a member's behalf.

The Case Manager will also respond to calls initiated by SOURCE members/caregivers or on behalf of members, again taking follow-up steps as necessary. While minimum standards for contact are described below, the Case Manager will communicate with or on behalf of members as often as necessary to meet Carepath goals and to stabilize or improve health status.

Direct contact between members/caregiver and providers or s also occurs frequently in the model; the Case Manager encourages engagement of the members/caregivers to the fullest extent possible in working toward optimal health and functional status.

Scheduled contacts with members/caregiver will occur according to the following timetable, at a minimum. The Contact Sheet and the Carepath will be used to record scheduled member contacts, appended by member case notes as necessary.

Monthly case notes must reflect what type of contact the Case Manager had with the member and a summary of what was discussed. Quarterly case notes must reflect review of member's Carepath, which will include goals not met, and a plan of improvement/correction. Case notes must reflect follow up to assure the plan is working, and resolution of identified problems.

1302. Procedures for Scheduled Contacts:

a) SOURCE Service Confirmation: The Case Manager will confirm initiation of services with the SOURCE member within two weeks of referral. The CM will take any follow-up steps required if services have not begun. Service referrals and confirmation will be indicated in case notes, on a Member Information Form (MIF) or on a SOURCE Referral Form.

b) Monthly Contacts: The Case Manager will contact all members a minimum of once each month, to be documented on the Contact Sheet and in case notes if necessary.
   (1) The Case Manager will indicate the method of contact (phone, home visit, other).
   (2) The Case Manager will review goals of the Carepath with the member/caregiver and will ask the member/caregiver to report any additional health or functional status issues, including initial PCP visit as applicable. On the Contact Sheet goals that are met will be checked; goals not met (variances) will be circled.
   (3) For Carepath outcomes with multiple goals, the Case Manager will indicate which particular goal was not met.
   (4) The Case Manager will take appropriate follow-up actions as indicated.
   (5) The Case Manager will sign and date the Contact Sheet for each monthly contact.
   (6) Monthly contacts will be documented by the Case Manager on the contact sheet, appended by case note entries if required for complete

documentation of service quality, progress toward goals and any other issues impacting care.

c) Quarterly Reviews: The Case Manager will formally review Carepath goals every quarter.

(1) At the member's home, the Case Manager will review goals of the Carepath with the member/caregiver. Goals will be documented as "met" or "not met" and dated in the third column of the member's Carepath. On the Contact Sheet, goals that are met will be checked; goals not met (variances) will be circled.
(2) The Case Manager will review the existing Carepath plan, making updates as indicated due to changes in health/functional status of the member, informal support changes, etc.
(3) For a goal not met, the Case Manager will discuss with the member/caregiver options on how best to resolve variance.
(4) The Case Manager will ask the member/caregiver to report any other issues potentially jeopardizing health or functional status.
(5) The Case Manager will observe the member's household for cleanliness and safety.
(6) Quarterly contacts will be documented by the Case Manager on the contact sheet, appended by case notes if necessary.
(7) The Case Manager will follow policy for Carepath variances.
(8) The Case Manager will take any additional follow-up actions indicated by the quarterly review.
(9) Changes to the Carepath plan will be documented, dated and signed by the Case Manager on the Carepath and the Member Version.
(10) New copies of the amended Member Version will be provided to:
- The member
- The Primary Care Provider
- All Providers

d) Re-evaluations: A formal re-evaluation will be completed for all members annually at minimum. These will be submitted to AHS following instructions in section 904:

(1) RN/LPN will complete the MDS-HC (V9) level of care assessment and the Case Manager/RN/LPN will complete the SOURCE Assessment form or another DCH approved Assessment tool. A new Records Release Authorization and Member Rights and Responsibilities must be signed and dated.

(2) The Case Manager will review the existing Carepath plan, services and any issues jeopardizing the health or functional status of the member at the re-evaluation, following the procedures for quarterly reviews.

(3) A new Carepath will be developed and reviewed for each member, following procedures from Policies II A, Self-care and Informal Support, II B, Completing the Carepath Document and II C, Initial Review of the Carepath.
(4) The level of care will be reviewed by the Case Manager and confirmed by the the Medical Director signature on the new Carepath, attesting to the member's current health and functional status. A new Level of Care form is initiated for the new member and members who are due re-evaluation (annually or more often as needed) by the RN/LPN with the use of the MDS-HC (v9) (see Appendix S) and Level of Care Justification form.
(5) AHS or DCH will validate Level of Care with the complete assessment package submitted by the Case Management Agency as of 9/30/2013.
(6) Recommended changes in the Level of Care will be reviewed by the site's multidisciplinary team as determined by the MDS-HC assessment as conducted by the RN/LPN.
(7) The R.N. and Medical director signature on the Level of Care form (Appendix F) should follow (as of 9.30.2013 after AHS validation) with multidisciplinary team review and confirmation

Note: an APPENDIX F must be completed, at least annually, to verify continued Level of Care eligibility; unless a legal notice is given to extend the expiration date.

(9) The re-evaluation will be further documented on the Contact Sheet by completing the annual re-evaluation section.
(10) The Case Management Supervisor will review and sign the new Carepath at the next monthly supervisory conference.

It is strongly recommended that at the Case Management 3rd quarter F2F visit, the Member is assisted to make a functional assessment appoint with their PCP. The functional assessment document should be given with explanation to the PCP for this visit and upon completion, submitted to AHS. See appendix NN for approved form.

(11) Should the Interdisciplinary team feel that a member no longer meets the nursing home level of care, the reassessment will still be sent to AHS for a second review with notification to AHS that the agency does not feel that the client meets LOC.

1303. Scheduled Contacts with Primary Care Provider

Primary care providers will routinely conference with the Case Manager to exchange information on the status of the member, identify problems quickly and target resources (informal and paid) effectively to resolve them. Areas are discussed and PCP recommendations are to be documented on the contact form in the case notes. Special attention should be given to any problems, variances, and all sentinel events that the member may have had since the last meeting. If the member has an annual re-evaluation schedule the next 3 months, concurrence with diagnosis, medications, and functionality should be discussed and documented with the PCP.

(9) Annual evaluation packet sent to member for review

1304. PROCEDURES

For all SOURCE members communication between the Case Manager and the primary care provider will take place at least bi-annually. Members/caregivers do not typically attend the conferences but may in the case of member compliance problems as a strategy to improve compliance with the medical or HCBS care plan.

Changes in health or functional status (including LOC changes)
Sentinel events with PCP recommendations documented
Carepath variances, with corrective actions discussed
Changes in Carepath since last conference
Equipment/supply needs
Medication List
Repeated hospital encounters, inpatient or emergency department
Administration of flu or pneumonia vaccines, when applicable
PCP concurrence of Level of Care at each Communication.
For new members: Review Carepath and significant findings from the initial PCP visit.

Recommendations by the Primary Care Provider, including changes to Carepath, will be noted by the Case Manager in the PCP Conference section of the Contact Sheet for discussion with the member. Extensive comments will be noted in the member's case notes. Note from the PCP conference may also be kept in a separate notebook.

Variances noted will be marked by circling the appropriate goal in the Primary Care Provider Conference section of the contact sheet/sentinel events that have occurred since the last discussion with the PCP, will be reviewed and documented.

Primary Care Provider and the Case Manager will sign and date the Contact Sheet in the PCP Conference section for all members.

The Case Manager Supervisor will decide staffing at Primary Care Provider conferences; all Case Managers or other staff may attend PCP conferences.

The Case Manager designated will review all PCP recommendations with case management staff.

The Case Manager with a member having chronic Carepath variances will attend the PCP meeting in person to discuss possible resolution.

1305: Schedules Contacts with Service Providers

In addition to the four principle themes of concurrent review described earlier, scheduled contact ensure that the SOURCE Enhanced Case Management and providers share the same understanding of services levels and responsibilities.

1306. Procedures for Scheduled Contacts with Direct Service Providers

Member initial referrals, discrepancies, discharges:

Initial Referrals: see SOURCE-Reimbursed Services.

a) All providers with members will submit to the site monthly reports of actual services delivered.

b) For members with services not delivered as ordered by the Case Manager, providers will include a brief explanation (hospitalization, service canceled by member or Case Manager, transportation problem, agency failure, etc.).

c) Each month, the site will reconcile the report with the actual services ordered.

d) Discrepancies will be identified and the site will follow-up as indicated with the provider, member/caregiver, etc.

e) For services over the level ordered or authorized by the site, the provider will complete an Adjustment Request Form to accompany refunds to the State for any

All providers with members will submit to the site monthly reports of actual services delivered.

f) For members with services not delivered as ordered or canceled by member or Case Manager, transportation problem, agency failure, etc.).

g) Each month, the site will reconcile the report with the actual services ordered.

h) Discrepancies will be identified and the site will follow-up as indicated with the provider, member/caregiver, etc.

i) For services over the level ordered or authorized by the site, the provider will complete an Adjustment Request Form to accompany refunds to the State for any

reimbursement for unapproved services (Note: CM may temporarily authorize community support services differing from the ordered hours, for a specific period of time and documented on a MIF; see SOURCE-reimbursed Services).

j) The provider will copy the Adjustment Request Form to the SOURCE Enhanced Case Management.

k) The site will send a correction in writing to the provider (using a MIF), listing the actual level of services authorized.

l) Due to complexity of care involved. Monthly conferences will take place with new services providers (as listed below) rendering services to a SOURCE agency's members for less than or equal to 6 months and who actively provide the following services to a member:

- Adult Day Health
- Personal Support/Extended Personal Support
- Alternative Living Services

m) Quarterly conferences will take place with providers serving a site's members for greater than 6 months of service delivery, unless otherwise specified on the SOURCE Case Management Internal/External Complaint Log, for these services

- Adult Day Health
- Personal Support/Extended Personal Support
- Alternative Living Services

NOTE: With the agreement of both the SOURCE Site (EPCCM) and the provider, conferences may take place either face to face or by a mutually agreed upon electronic method. Provider conferences will include for members served by the agency, efforts to resolve:

- Member Carepath variances and sentinel events
- Potential nursing home placement
- Member service issues and service delivery complications
- Discrepancies in services ordered/authorized
- Provider performance issues
- Provider training and education needs
- Review of documentation needs for the service provider's member record and provision of same

j) The site will maintain written minutes from the conferences. Minutes will be maintained in one central location and sites may choose to document individual member's file for additional information as well.

k) The Case Manager will provide follow-up action necessary following provider conferences (examples: communicating with family to ensure that adequate food or supplies are available, following up with members not home for service, discussing with Primary Care Provider a referral for behavioral care for an ALS resident, etc.)

l) Following completion of the annual re-evaluation for each SOURCE member, the case manager will send to each provider the updated Member Version of the Carepath. Changes in service units or schedules or significant changes in responsible parties will be accompanied by a MIF to provider affected.

m) For discharges initiated by the SOURCE Enhanced Case Management, the provider will confirm notice of a service discharge by sending a completed Member Information Form (see Appendix W) to the Case Manager.

n) For discharge of a member initiated by the provider, the provider will notify the site of a discharge using the Member Information Form. Discharge by a provider should ONLY occur after:
   (1) The provider has exhausted all possible avenues to resolve issues complicating service delivery
   (2) The provider has included the site in attempts to resolve issues complicating service delivery, from the initial identification of a problem
   (3) The provider has followed waiver requirements for giving notice prior to a discharge date

1307. Scheduled Contacts with Case Management Supervisor

A formal supervision process supports the Case Manager in negotiating complex situations among multiple parties. Case Management supervision serves four main functions, ensuring that:

- The Case Manager has benefit of the supervisor's additional experience and perspective
- The Case Manager has administrative support in making difficult decisions
- Individual member's Carepath goals are met
- The program's direction is sustained

1308. Procedures

a) The status of high risk members will be reviewed by the Case Manager and Case Management Supervisor at least monthly, to:

   - Discuss Carepath variances and subsequent corrective actions
   - Update support service plans as necessary to meet Carepath goals
   - Analyze repeat hospital encounters
   - Resolve other issues possibly jeopardizing health or functional status
   - Review and sign Carepaths for new and re-assessed members

b) The site will maintain written minutes from the conferences. Minutes will be maintained in one central location and site may document on the individual member's charts.

c) Recommendations on changes of the Carepath level or Level of Care will be included in supervisory meetings.

(1) The Case Manager will request the RN/LPN complete a new Level of Care Assessment using the MDS-HC.

(2) The Case Manager will present the LOC change for review and approval by the multidisciplinary staff committee; the SOURCE medical director or PCP will sign the Carepath, confirming the new service level or the APPENDIX F
to demonstrate the interdisciplinary team's agreement that the member does not meet LOC.

d) Recommendations for changes in Carepaths will be reviewed at supervisory meetings. The Case Management Supervisor will approve all changes in service plans (see SOURCE-Reimbursed Services).

e) The Case Management Supervisor will sign the Contact Sheet within thirty days following the quarterly home visit.

1309. PRN Contacts

Problems complicating the lives of people with chronic illness may not coincide with scheduled monthly or quarterly Case Manager contacts. The SOURCE model places responsibility on Case Managers to ensure that communication with or between the right players happens at the right time to meet program and Carepath goals.

Communications with members (and subsequent follow-up actions) that fall between scheduled contacts are made in response to member need. While most such contacts fall into areas related to clinical/functional status or service delivery, members may also contact Case Managers about eligibility, housing, items not covered by third party payers, etc. – in short, any issue potentially jeopardizing their ability to continue living in the community.

Access to Primary Care Providers – as needed to manage clinical or behavioral complications of members – is a cornerstone of the program. Effective Primary Care Provider participation is key in helping Case Managers extend the limits for chronically ill people living safely in the community. Given the vulnerable nature of the population SOURCE serves, Primary Care Provider response to unscheduled interactions must be characterized by promptness, creativity and perseverance in problem solving.

Providers (particularly PSS/EPS, ADH and ALS) frequently develop a close relationship with members/CG for several reasons:

- The frequency with which they encounter members/CGs
- The intensely personal nature of community services
- The social isolation of some members

Given these factors, participating providers are in an unrivaled position – and have an unrivaled responsibility – to assist members by ensuring that communication channels stay open.

Communication with the Case Manager Supervisor around identified triggers is also critical, allowing the Case Manager to share the substantial responsibility of making decisions and taking actions that best support members in community living.

Procedures:

1. All key players in the program will be encouraged to report to Case Manager's any issues that threaten a member's health status or ability to live in the community.
2. All key players will be educated on using the SOURCE 24-hour phone number for case management and primary care assistance offered from the site.
3. All key players will identify a key contact person to facilitate and communication for SOURCE members (may be the actual member, as indicated).
4. The individual SOURCE CM assigned to a member is the contact person identified for key players.
5. Triggers for PRN communication between players are:
   - Carepath variances
   - Potential nursing home placement
   - Hospital encounters—inpatient or emergency department
   - Acute illness/exacerbation of chronic condition
   - Significant change in function—physical or cognitive
   - Suspected abuse or neglect
   - Service delivery complications
   - Housing/other residential issues
   - Family dynamics/informal support changes
   - Transportation needs
   - Member's desire to appeal a Case Manager decision Other factors jeopardizing health/functional status or community residence

Additional PRN communication with PCPs includes:

- New patients with SOURCE (review Carepath; file copy on chart)

- Episodic/acute illness or exacerbation of chronic illness
- Medical triage/advice
- Referral to/communication with specialists (or ancillary services, diagnostic, etc.)
- Scheduling appointments
- Urgent equipment/supply needs
- Pharmacy/prescription needs

6. Triggered information will always flow from other key players to the CM.

7. If a specific CM is unavailable, the key player can relate information to the CM on call or to a CM supervisor.

8. Triggered information will flow from the CM to key players as indicated to resolve problems and achieve Carepath goals; in the interest of member privacy and staff energy, care will be taken to involve only player's essential in resolving/preventing a specific problem.

9. Case Manager's will document PRN contacts and follow-up actions in a member's case notes, on Contact Sheets or on Carepaths as indicated.

10. Case Manager's will take any follow-up actions indicated to resolve outstanding issues (see also Policy II F, Carepath Variances), facilitate services or prevent further complications. Examples of follow-up actions includes:
    - Changing Carepath levels, increases or decreases
    - Evaluating functional changes by a home/hospital visit
    - Scheduling a medical appointment
    - Arranging a family conference to resolve care giving responsibilities
    - Making transportation arrangements
    - Referral for DME
    - Assisting member in obtaining non-covered supplies
    - Changes in Level of Care as determined by MDS-HC

11. Changes in service level will require approval by the Case Manager and the Case Manager supervisor or program manager.

12. The Case Manager will communicate changes to the provider on the MIF (see Appendix W); a return MIF from the provider confirming the new service level is required.

13. For communication with or on behalf of members falling between scheduled monthly or quarterly contacts, the Case Manager will use a case note narrative format with the contact's name, date and manner of exchange (phone, home visit, etc.) and a brief description of the exchange (see Definitions, Case Notes). Examples include contact regarding service delivery, arranging transportation, etc. Problems, follow-up

activity and problem resolution should be documented in case notes. All contacts will be initialed and dated by the Case Manager.

1310. Disease State Management

The SOURCE Disease Management design primarily employs Carepath variances to identify high-risk patients within the program, and incorporates traditional DM protocols of tracking, education and self-management into the existing SOURCE structure and processes. DM principles are consistent with the SOURCE focus on outcome measures, primary medical care, regular feedback to all key players and the inclusion of informal support in providing care.

DISEASE MANAGEMENT STRATIFICATION/INTERVENTIONS:

1. SOURCE will primarily identify members requiring the new level of disease management using two criteria: diagnosis and variances. (Additional avenues into disease management will be noted at the end of the stratification section.)
2. All sites will have an internal mechanism for indicating on member charts the current DM stratification level.
3. Disease states targeted include diabetes and hypertension, with additional conditions as identified by the Department of Community Health.
4. Variances targeted:

All Disease States

- Clinical indicators (BS, BP, weight as indicator of illness, lab values)
- Nutrition Goal B. (diet recommended by PCP)
- Medication compliance

Dementia/Mental Health – additional variance

- Behavior Goal B. (problem behavior management)

Obesity – additional variance

- Nutrition Goal A. (weight posing critical health risk)

Members identified for high-risk disease management must meet both the diagnosis criteria and the variance criteria described below.

5. SOURCE uses three levels of stratification (low, medium and high) based on variances. Each level of stratification will involve applying escalating resources. While the first two levels (low and medium) will receive patient education around their disease states, only the third level (high risk) will be included in the full disease management program.

A. Low risk – well managed (i.e., meeting Carepath goals, no variances)

PLAN:

Conventional SOURCE enhanced primary care case management for preventive measures

INTERVENTIONS:

- Protocols
  - Carepath development
  - Concurrent review
- Member education on targeted disease states
- Time frame – at first quarterly home visit following enrollment

TRACKING:

- Carepath outcomes
- Hospital encounters
- Time frame – formally recorded each quarter

DURATION:

- Preventive efforts - ongoing for length of stay in SOURCE

B). Moderate risk – occasional variances of targeted Carepath goals

PLAN:

Conventional SOURCE enhanced primary care case management with PRN response to individual variances. Review of variance and options for corrective action by case management supervisor and SOURCE PCP. Adjustment of Carepath plan as indicated.

INTERVENTIONS:

- Protocols
  - Carepath
  - Concurrent review
  - Variance protocols (corrective action)
- Member education on targeted disease states

- Time frame – at or before next quarterly home visit

TRACKING:

- Carepath outcomes
- Hospital encounters
- Time frame – formally recorded each quarter

DURATION:

- Corrective actions - until resolution of Carepath variance; preventive efforts - ongoing for length of stay in SOURCE

C). High risk – members with three consecutive variances of the same targeted goal*

PLAN:

Conventional SOURCE EPCCM; review by case management supervisor, PCP and medical director for chronic variances; disease management for targeted conditions

INTERVENTIONS:

- Protocols

Carepath

Concurrent review

Variance protocols

Evidence-based practice protocols/tracking logs

Self-management goals

- Member education
- Time frame: additional home visit at next monthly contact (replaces phone contact) following identification of consecutive variance

TRACKING:

- Carepath outcomes – formally recorded each quarter
- Hospital encounters
- Clinical outcomes specified by EBP protocols on tracking logs for targeted condition

DURATION:

Resolution of variance(s) and/or recommendation by PCP

*Sites may also choose – on a case by case basis – to review members for high-risk disease management of targeted conditions under the following circumstances.

Hospitalizations – repeat encounters, within 30 days

New admissions into SOURCE, based on history of poorly managed chronic condition

New onset of a targeted condition

PCP recommendation based on poor management of a targeted condition.

Targeted variances other than three consecutive variances of the same goal, with site recommendation (example: sequential variances but not of the same goal; simultaneous variances within a quarter, etc.)

Prior to implementing high-risk DM under any of the alternative routes described above, the DM referral shall be reviewed by the CM supervisor and the site Medical Director.

HIGH-RISK DISEASE MANAGEMENT:

1. In addition to meeting established stratification criteria, the member's PCP must also concur that the member is appropriate for high-risk DM. At any point during high-risk disease management, the PCP may also recommend DM disenrollment based on non-compliance or other clinically complicating factors.

2. Tracking logs will be completed to the best of the CM/PCP team's ability. Information requested that is not available will be so indicated on the tracking log, in the appropriate section. To indicate that a protocol was not followed (example: no foot exam performed at an office visit on the diabetes log), a straight line should be drawn across the appropriate section.

3. Self-management goals are educational materials that do not require PCP signature but are considered generically applicable to all SOURCE members on high-risk DM.

4. PCPs will indicate review of any applicable DM tracking logs by signature on the SOURCE contact sheet in the PCP conference section (amended contact sheets will include a statement to that effect).

5. SOURCE Case Management Provider will promote use of evidence-based practices by key players in the following ways:

a). Track key protocols – SOURCE DM tracking logs for targeted conditions

b). Track key clinical measures – SOURCE tracking logs for targeted conditions

c). Track self-management goals for targeted conditions

d). CM and PCP are a team in monitoring indicators. Tracking tool will be kept in CM chart, optionally in PCP chart as well

e). Medical Director/PCP blanket sign off on education plan/self-management goals – CMs to reinforce PCP recommendations with educational material; clinical questions referred to PCP

f). Education initiatives for CMs

Basic explanation of disease process

Education on materials to be used

Commonly asked questions

Education on protocols

g). Standardized education materials written for potentially low-literacy population:

Brief, Simple, Large type

Emphasize small changes in lifestyle

Meaningful in laymen's terms

6. To facilitate self-management of condition, sites will, as feasible:

a). Include key players in education and management of condition

Member

Informal caregivers

SOURCE providers

Provide PSS/ALS/ADH providers with education recommendations

ID specific related tasks: meal prep, med. /monitoring cueing, etc.

Implement self-management goals

b). Ensure proper equipment

Examples: One-Touch, Log Book, Scales

Diet/food diaries Exercise Logs

7. Routine reporting and feedback will be accomplished in SOURCE by incorporating DM issues and protocols into the conventional concurrent review process - scheduled and PRN.

- Member/caregiver contacts
  Additional education visits at outset of DM

  Monthly contacts

  Quarterly home visits
- Weekly medical director meetings as indicated
- Quarterly PCP meetings (including clinical measures and protocol reviews)
- Monthly provider meetings
- PRN contacts as needed with all key players re: adherence to protocols, education issues, other follow-up

8. Collaboration among providers will be ensured via:

a). Incorporating disease management into existing concurrent review processes (see above)

Key players

Ad hoc players (skilled nursing, hospital CM or d/c staff, etc.)

b). Considering as appropriate use of skilled nursing in patient education and tracking (Medicare, Medicaid or waiver HDS)

c). Incorporating meeting DM goals into concurrent review, as well as Carepath outcomes

9. The following outcomes measures will be employed through SOURCE disease management:

a). Carepath outcomes (targeted goals – see Section 1310, No. 4) b). Clinical measures from tracking logs for targeted conditions

To function effectively and assist members in meeting program goals, all key players in SOURCE must provide accessible, effective and reliable service. Enhanced Primary Care Case Management providers will comply with all monitoring and reporting activities as required by the Department of Community Health/Division of Medical Assistance. Sites are responsible for routinely monitoring the performance of network providers, both Primary Care Providers and HCBS agencies.

Conflict Free Case Management is required by the federal government. DCH restricts agents that conducts the functional assessment and/or case management to also provide services to that individual. See Appendix RR.

Procedures:

SOURCE CASE MANAGEMENT SITES

DCH LONG TERM CARE UNIT MAY REQUIRE A CORRECTIVE ACTION PLAN (CAP) FOR NON-COMPLIANCE IN THE FOLLOWING AREAS. PLEASE SEE THE REFERENCED SECTIONS FOR COMPLIANCE REQUIREMENTS:

- Source Programmatic Report (See Appendix JJ). (monthly)
- SOURCE Case Management Team Meetings Documentation (See section 806)
- Management of Community Service Provider Performance (See section 807)
- Program admission procedures: submitting all documentation to AHS (See section 903)
- Program admission procedures: documents submitted to providers (See section 903)
- Care Path Formal Review Documentation (See section 1004)
- Member Forms in Chart; forms present and documentation complete (See section 1300)
- Scheduled Contacts with Primary Care Providers (See section 1305)
- Disease State Management Initiation and Tracking and Intervention Logs (See section 1308)
- Maintaining 24 hour call system: documentation and maintaining system (See section 1402)
- Hospital tracking and intervention Logs (See section 1308 and 1403)
- Utilization Management oversight documentation (See section 1401)
- Standards of Promptness (See Appendix H)

Including submissions to AHS are prior to level of care expirations (timely)

- Discharge planning documents: Complete and Comprehensive discharge planning documentation (See appendix Z6-8 and section 806)
- Guardian notification occurs as outlined (See 902 Procedures (d) and 1406 Right to Appeal)

DCH may require a Corrective Action Plan (CAP) for non-compliance. Sites must

submit a CAP within 14 calendar days of notice of non-compliance and Corrective Action Plan. If an approved CAP is not properly.

applied or executed, DCH may impose additional sanctions ranging from new member suspensions up to suspension of participation as a Case Management Agency. The areas listed above are frequently requested areas, SOURCE Case Management Companies are still required to follow all SOURCE policy.

HCBS PROVIDERS (HOME AND COMMUNITY BASED SERVICES PROVIDERS) WILL BE MONITORED BY SOURCE CASE MANAGEMENT FOR THE FOLLOWING (INCLUDING INFORMATION FOUND IN APPENDIX HH AS OF 7.01.2013):

- Services delivered as ordered by the case manager, including – as applicable – units of service, service schedule, tasks, time frame, personal preferences as feasible, etc.
- Prompt and effective communication with sites and members/informal caregivers, at all points during a member's tenure with a provider, as described in Concurrent Review Policies No. 1306 and 1309
- Commitment to serve members with challenging personal situations or diagnoses
- Demonstrated efforts to serve manpower shortage areas
- Willingness to flex service levels as authorized by the case manager, in response to the complex or unpredictable status of individual members
- Customer satisfaction standards that exceed basic licensing requirements; specific areas of accountability include:
    - Reliability of service
    - Competency, compatibility and consistency of staffing (where applicable)
    - Responsiveness to member and staff concerns, including Carepath variances
    - Complete and timely submission of monthly service delivery reports and resolution
    - Continued status in good standing as a Medicaid provider
    - Adequacy of on-call arrangements for after-hours and weekends

  Note: More Information on Provider Performance Monitoring and Corrective Action by CM agency to HCBS providers including removal or suspension from the Active Provider list can be found in Appendix
  Monitoring methodologies for HCBS providers include but are not limited to the PSS/EPS service delivery score, the Case Management Complaint log and the quarterly Carepath goal related to satisfaction with all HCBS services.

PCPS WILL BE MONITORED BY SITES FOR THE FOLLOWING:

- Appointments – ease of scheduling, initial visit and ongoing appointments
- Conference logistics – scheduling, preparation, wait time, space
- Conference – adequate time allotted quality of PCP participation in discussion and grasp of SOURCE, etc.
- PRN contacts – accessibility (response time of PCP and/or office staff); effectiveness of PCP and office response; on-call response; appropriately identifies existing patients needing referral to SOURCE
- Disease management – accessibility of clinical data required and quality of participation in discussion

4. HCBS providers or PCPs not performing in accordance with standards set by the site or by the DCH SOURCE policy and procedure manual may be subject to review for continued participation with the site.

1401. Utilization Management

As stewards of significant state funding via the authorization of HCBS services, SOURCE Case Management Provider must ensure that the value of Medicaid's long-term care dollars is maximized. Sites will develop an internal system of monitoring and managing utilization of authorized home and community based services. Conflict free Case Management assists to restrict conflict of interest by separating Case Management from Direct service providers. See Appendix RR.

Procedures:

1. Case managers will capitalize on self-care capability and informal support whenever feasible, and family care will be supplemented rather than replaced. Case managers will facilitate informal support with training and equipment as necessary.

2. At the site's admission committee, the case management team (including the medical director) will review recommendations to ensure the appropriateness of each service category; generally, least restrictive setting or service to achieve goals is preferred by members and is often less costly.

3. Sites will work to maintain function and overall health by addressing areas that may lead to increased impairment and higher HCBS costs – effective medical care, adequate housing, Carepath goals (nutrition, medication adherence, etc.).

4. Case managers will use creativity in developing Carepath plans, employing community resources other than Medicaid-reimbursed services that will contribute to meeting Carepath goals.

5. Sites will maintain case manager awareness of the relationship between age and/or progressive illnesses and the increased need for paid services; case managers will develop initial Carepath that are sufficient to meet goals but do not have extra capacity, to ensure that members may receive additional services if their level of impairment or informal support changes.

6. Sites will benchmark service plan costs by level, according to site averages or using information provided by the Department of Community Health for all SOURCE Case Management Provider.

7. Upon admission, sites will calculate service plan costs for comparison to the benchmarked standards.

8. Outliers will be reviewed further by the medical director, site manager and case management supervisor. Adjustments to service plans will be made when appropriate; balancing costs of care with achieving program and Carepath goals.

9. Sites will develop an internal method for the ongoing identification of outliers that exceed benchmarked standards established by the site or by DCH. Triggers may be service costs, units of service, etc.

10. Upon completion of enrollment and initiation of services, case manager will provide the following documents to all community service providers:

- The MDS-HC with Medication List, and Appendix T
- SOURCE Assessment Addendum C1-5,
- SOURCE Level of Care and Placement Instrument (must contain required signatures and date of signature)
- Level of Care Justification (Appendix I)
- The SOURCE Carepath detail (Appendix J, L, or N)
- Member Version of the Carepath (initial paperwork may be an unsigned version, signed versions must be sent after member signature procurement)
- Rights and Responsibilities
- Advance Directives if available to Case Management (See Section 903 (j)
- Directions to the member's home, starting from the local Source site Office to the member's home address (See Section 902, Procedures (k))
- Consent for Enrollment (Appendix C7) for initial and annual enrollment
- Referral Form (Appendix V) for initial and annual enrollment and when member has notable changes
- SOURCE Member Information Form (MIF) (only when member has notable changes)

1402. 24-Hour On Call

SOURCE Case Management Provider will maintain a 24-hour a day/sevendays per week/365 days per year on-call system that will:

- Optimize primary medical care for members by offering prompt attention to clinical complications or illness

- Assist members and informal caregivers in addressing after-hours service delivery issues promptly
- Help members avoid unnecessary emergency room visits by medical triage and advice

All sites will maintain a 24-hour phone line answered by a live voice.

a) At assessment, the case manager will leave for the member written information on how to contact the SOURCE Enhanced Case Management, including the 24-hour phone number.

b) Education for members by the Case Manager on using the 24-hour line will be included at the assessment home visit.

c) Access to the following services will be provided or facilitated via the 24-hour phone line:
   (1) After-hours medical triage and advice
   (2) After-hours medical consultation by SOURCE Primary Care Provider or designated qualified medical professional
   (3) Assistance in resolving service delivery complications, after hours
   (4) Authorization of medical services

d) Authorization of community services including increase or decrease in service (also using the site-specific SOURCE number) must be approved by Case Management staff, with confirmation on the appropriate forms.

1403. Health System Linkages

SOURCE differs from conventional HCBS in Georgia in part by including primary care providers as partners in case management. To meet program and Carepath goals, SOURCE Case Management Provider assume responsibility for coordinating overall healthcare services for members. Sites must work with local healthcare facilities in collaborative arrangements to reduce conflicting and duplicative efforts. Sharing information on current health conditions, assistance needed and resources available benefits the members and promotes program goals. Coordination between the site and healthcare organizations (particularly hospitals) ensures that decisions for nursing home placement of members will not occur without:

- Exploration of all possible routes to a community-based plan
- Primary Care Provider consultation
- Advocacy efforts by CM, in coordination with family/informal caregivers

For all services delivered by non- reimbursed organizations, the Case Manager must take three steps: identify when a service is in place, coordinate efforts with the staff and track the service until discharge.

Procedures:

1. Hospital Linkages:

a) SOURCE Case Management Provider will maintain ongoing coordination with acute care facilities, ensuring hospital coverage of the entire service area.

b) Areas included for coordination are:
   (1) Communication with family members around hospitalizations
   (2) Discharge planning, emphasizing community plans over institutionalization and referral to SOURCE-affiliated providers
   (3) Treatment conferences for extended LOS patients
   (4) Preventive efforts re: repeated hospital encounters

c) Case Manager will educate members/caregiver on using hospitals affiliated with the SOURCE Enhanced Case Management, upon enrollment and throughout the member's length of stay.

d) Sites will track inpatient admissions, by following protocols of the Hospital Tracking Form (see Appendix), facilitating discharge. The Hospital Tracking Form may replace a case note regarding the hospitalization for that member.

e) Hospitals coordinating with SOURCE are requested to communicate with the SOURCE site relative to hospitalized members for collaboration in discharge planning.

2. Home Health Services

a) SOURCE Case Management Provider will maintain ongoing coordination with home health agencies, ensuring effective and non-duplicative home health services for members indicated.

b) Areas for coordination include:
   (1) Services provided by agency and by SOURCE
   (2) Communication with Primary Care Providers
   (3) Resolution of Carepath variances
   (4) Preventive efforts to meet Carepath goals
   (5) Discharge planning

c) Case Manager will educate members/caregiver and hospital staffs on using home health agencies affiliated with SOURCE, upon enrollment and throughout the member's length of stay.

3. Dialysis Centers:

a) SOURCE Case Management Provider will maintain ongoing coordination with area dialysis centers, ensuring effective and non-duplicative dialysis services for all members indicated.

b) Areas included for coordination include:
(1) Provision of primary care services
(2) Authorization of healthcare services
(3) Case management responsibilities
(4) Resolution of Carepath variances
(5) Preventive efforts to meet Carepath goals
(6) Hospitalizations

c) A dialysis center physician may serve as a participating Primary Care Provider, if he or she agrees to perform the functions described under "SOURCE Primary Medical Care" and in the Scheduled Contacts – Primary Care Providers and Policy, PRN Contacts.

1404. Member Discharge

Discharge Planning Policy Statement:

Discharge planning is instituted at the beginning of the SOURCE participation to assist a client in making the transition from one service environment to another

Discharge planning is conducted to: Plan for continuity of an individual's health care; Maintain the individual's level of functioning; Lower an individual's readmission rates to medical facilities (for example: hand rails in bathroom to prevent falls)

Process for Discharge Planning:

Complete the following activities at enrollment to ease planning at discharge:

Begin to develop the discharge plan during the initial assessment (document what the member will need if discharged)

Reflect discharge planning in care plans by utilizing the steps in 1401 that ensure maximize funding (i.e. keep family resources in place, use community resources)

Coordinate discharge planning in consultation with the client's physician, other involved service agencies, and other local resources available to assist in the development and implementation of the individual's discharge plan. (Track key providers in member's well-being, consult with them as necessary)

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See Appendix BB and Z6 and Z7-8 for more Information on operationalization of discharge planning.

Discharge Policy Statement:

SOURCE Members can be discharged for a variety of reasons. Voluntarily or Involuntarily. SOURCE supports and when possible improves the member's functioning. If evaluation or occurrences support discharge, SOURCE will work to make the transition as smooth as possible.

Process for Discharge:

The Case Manager will exhaust all means to ensure that members continue their enrollment in the program, for several key reasons:

- Members constitute a vulnerable population due to chronic illness, disability, advanced age and low-income
- Managing non-compliance is a core function of the CM/Primary Care Provider team
- DCH expects sites to meet or exceed consumer expectations

Discharge from the program may be either voluntary or involuntary. Reasons for discharge include:

- Member moves from the site's service area
- Member enters a facility or institution (see same guidelines for Nursing Home)
- Member does not meet eligibility using the definition in section 801.3 disability and Intermediate Nursing Home Level of Care Criteria
- Member is no longer eligible for full Medicaid
- Member death
- Member transfers to another waiver program
- Member is admitted to a nursing home (may hold for 100 days)
- Member Choice
- Member is chronically non-compliant (non-compliance includes continued abuse of alcohol or drugs)
- Member health and safety needs cannot be met in the community
- Member's health and functionality is not confirmed by the Primary Care Provider's documentation or other appropriate physician specialist

This section is appended by Section 1406, Right to Appeal.

a) Voluntary Discharge
Enrollment in SOURCE is strictly voluntary. Case Managers will make all feasible efforts to meet the reported and observed needs of persons in service. However, a voluntary discharge will be effective immediately as of the date requested by the member, guardian or custodial caregiver.

<u>Procedures:</u>

(1) A Case Manager's efforts to reconcile the source(s) of a member's dissatisfaction with the program may include as indicated:
- Conferences with providers, Case Manager and members/Caregivers
- Changing provider, PCP or Case Manager

- Discontinuing an individual service or otherwise altering the Carepath plan
- Involvement of the supervisor, Primary Care Provider or program management

(2) If efforts to resolve a member's or caregiver's dissatisfaction with SOURCE are unsuccessful, the consequences of disenrollment from SOURCE will be explained:
- Case Management services from site discontinued
- Community services reimbursed by SOURCE discontinued
- PCP services coordinated through site discontinued

(3) If other HCBS programs are enrolling the member following discharge from SOURCE, the Case Manager will work to make the transition happen smoothly.

(4) Services reimbursed by SOURCE will be discontinued effective on the date so requested by the member, or the date the member becomes ineligible.

(5) Upon learning of an effective discharge date, the Case Manager will notify:
- SOURCE providers, by completing the Discharge section of the Member Information Form (MIF)
- Providers not reimbursed through SOURCE
- The SOURCE PCP office

(6) The member's PCP may continue providing primary care services following discharge from the program if requested by the member and agreed to by the PCP.

(7) Upon discharging the member, the Case Manager will complete the SOURCE Discharge Summary Form in its entirety (Appendix BB), and Appendix Z (7) to be filed in the member's chart.

(8) Once discharge of services occurs,

Once discharge of services occurs, make sure the Service Prior Authorization lines are end dated.

1405 SOURCE MEMBER INVOLUNTARY DISCHARGE

Involuntary Discharge

Effectiveness of SOURCE services depends heavily on the participation of members/caregivers in developing and implementing the Carepath plan. A prolonged or repeated pattern of deliberate non-compliance may result in involuntary discharge from SOURCE.

Discharge from SOURCE, however, does not end a member's Medicaid eligibility.

Only after thorough efforts by the site to resolve patterns of non-compliance will SOURCE members be involuntarily discharged. Examples of non-compliance include but are not limited to:

- Failure to keep scheduled Primary Care Provider appointments
- Avoiding or refusing Case Manager visits or other contacts
- Refusal to allow or facilitate the delivery of community services as agreed on in the Carepath plan
- Failure to provide essential information affecting SOURCE's ability to help members live in healthy and functionally independent ways
- Refusing to participate in problem solving discussions and efforts with Case Manager's, PCP's, physicians or providers around Carepath variances, delivery or clinical issues
- Failure to use designated SOURCE providers or affiliates for services

Discharge occurs when:

1. The case manager determines that the member is no longer appropriate or eligible for services under SOURCE
2. DCH Program Integrity staff recommend in writing that a member be discharged from service
3. Member/member's representative consistently refuses service(s)
4. Member's physician orders the member's discharge from SOURCE
5. Member enters a medical facility. (The provider may decide to send the notice of discharge immediately upon the member's placement in a medical facility or in the case of facility admission expected to be 100 days or less the Case Management Agency may suspend the Service Prior Authorization, Assessments, Carepath, etc.)
6. Member 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.
7. Member/member's representative or case manager requests immediate termination of services. The provider must document in the member's record the circumstances that led up to termination.

8. Member moves out of the planning and service area to another area not served by the provider. (If requests a transfer of services, this needs to be coordinated by case management to ensure continuity of care)

9. Member expires.

10. Provider can no longer provide services ordered on the Carepath. (see also section 1306 Discharge… initiated by the provider)

11. Member is non-compliant. Examples of non-compliance includes:
    - Failure to keep scheduled Primary Care Provider appointments
    - Avoiding or refusing Case Manager visits or other contacts
    - Refusal to allow or facilitate the delivery of community services as agreed on in the Carepath plan
    - Failure to provide essential information affecting SOURCE's ability to help members live in healthy and functionally independent ways
    - Refusing to participate in problem solving discussions and efforts with Case Manager's, PCP's, physicians or providers around Carepath variances, delivery or clinical issues
    - Failure to use designated SOURCE providers or affiliates for services

Procedures for Discharge:

1) The assigned Case Manager will communicate clearly at admission the program's expectations of members/caregiver.

2) The Case Manager will state that program eligibility requirements and reevaluation is needed to remain on the SOURCE program

3) Single, minor or isolated instances of non-compliance will not result in formal action; the Case Manager will address these issues with members/caregiver as they occur.

4) The Case Manager will take action steps indicated for repeated instances of non-compliance, involving as indicated the member's PCP, supervisor or program manager (see Policy II F, Carepath Variances).

5) Issues of non-compliance and efforts at resolution will be documented in the member's case notes, on the Carepath, in Variance Reports, etc.

6) The multidisciplinary team staffing the admissions process will be the entity to hear, explore and decide issues of pending discharge due to non-compliance

7) The Primary Care Provider will be informed of pending involuntary discharge prior to the disenrollment's effective date.

8) Prior to discharge, a member (or custodial caregiver or guardian) will receive from the Case Manager – following approval by the site's multidisciplinary group – written warning of potential discharge with a suggested course of action required to avoid discharge.

9) For members/caregiver unable to read, the Case Manager will read the letter over the phone or in person; the letter will also be mailed to the member's house.

10) Should the first written warning fail to resolve a pattern of non-compliance, members (or custodial caregivers or guardians) will receive from Case Manager (with approval from the multidisciplinary group) a written deadline for the course of action necessary to avoid discharge.

11) If the member fails to meet the letter's deadline, the Case Manager will initiate steps to discharge.

12) The Case Manager will make referrals to other programs or agencies if the dis-enrolling member so requests.

13) The Case Manager will facilitate the transition to other agencies in all ways possible.

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14) Members will be informed in writing of the formal date of discharge from SOURCE.

15) Members may further seek to appeal an involuntary discharge through the Department of Community Health's appeal process.

16) Members may be involuntarily discharged immediately from SOURCE by the site's multidisciplinary staff group for criminal activities by member or in the home, and physical aggression toward providers, CM or PCPs, by member or in the home environment bypassing procedures 3 through 13.

17) Upon discharging the member, the CM will complete the SOURCE Discharge Summary Form in its entirety (Appendix BB) and Appendix Z(7-8), to be filed in the member's chart.

18) Upon discharge, the CM will send AHS a discharge notification through contact us or (preferred) send designated form through contact us and

a) End date all the Service Prior Authorization lines with appropriate date.

Procedures for Suspension of Service Prior Authorization

1. For suspension of services which will allow a member's Service PA to be reactivated and maintain LOC Prior Authorization the CM and PA builder should take these steps:
   1.1. End date all Direct Service Provider (DSP) Lines with the date the member entered the Medical Facility (please do this after checking to make sure DSP billing dates are in alignment with the end date desired)
   1.2. Leave Case Management Service line date to mirror Service Prior Authorization end date. (This will signal to AHS that the Case Management agency has not terminated the member. Member is in suspense)

1406. Right to Appeal

The DON-R Score, Failure to meet eligibility including Nursing Home Level of Care, Reduction in Services or other SOURCE Terminations

A. SOURCE members and applicants have the right to appeal the following actions of a SOURCE Enhanced Case Management site:

- The DON-R score (but may not appeal agency refusal to screen assess based on initial information)
- Denial of eligibility (category of eligibility other than SSI or Public Law or no category; failure to meet nursing home level of care; refusal based on other factors like service area, available housing, safety concerns, etc.)
- Reduction in services (any reduction in service, even resulting from a temporary increase)
- Termination of services (discharge from SOURCE)

The Department of Community Health will notify sites when a request for an appeal is made, and when a request is made to maintain services at the current level. Agencies are not to reassess a client while the client is under an appeal request or Request for Fair Hearing (RFH) unless;

A) Greater than 9 months since last assessment (waiver requires annual assessment)
   a. Notify AHS and submit with information on circumstances in contact us
B) Reassessment has been approved by DCH.
   a. Notify AHS and submit with information on circumstances in contact us

Sites should note that this policy applies only to SOURCE-reimbursed services.

Procedures for Issuing Discharge Notice from Case management Agency:

Case managers and CM supervisors will attempt to reach consensus with members and potential members (or legal guardians if applicable) on decisions made about the member's care. SOURCE sites will involve the primary care physician and/or Medical Director in all decisions resulting in adverse action.

Members who fail to meet the eligibility criteria including Nursing Home Level of Care will be reviewed by the Interdisciplinary team prior to issuance of the Appendix Z (notification of adverse action). The assessment nurse will present, or, at a minimum, be available to answer questions about the member's MDS-HC assessment, additional assessments and any other documents used in the LOC determination, to the interdisciplinary team for review and discussion.

If the team agrees that the member does not meet eligibility, the Medical Director and/or PCP will indicate same in item 34 of Appendix F and sign his/her name as required.

1. Following discussion of an action falling into any of the categories described above, the site will inform the member clearly of the action to be taken.

2. Unless AHS issues the written notice, sites will give the member written notice, sent via Certified Mail, of actions for any of the categories, using the Appendix Z-1 letter, NOTICE OF DENIAL, TERMINATION, REDUCTION IN SERVICE. The form will be dated the day the form is mailed.

3. Sites are not to issue a discharge letter (Appendix Z form) if AHS has issued the decision. Sites may download AHS's written notice from the AHS web portal and take to client if client is not aware of notice, or has not received notice through mail.

. 4. The original Z-1 letter is mailed to the SOURCE member via Certified Mail, along with the Appendix Z-2 Notice of Right to a Hearing form. After conferring to the member Appendix Z 7 is completed. A copy is kept in the SOURCE chart.

For members concurring with the intended action, the Appendix Z-1 letter and the Appendix Z-2 and Z-7 form will also be completed and provided to members as described above.

5. Members have 30 days from the date of their Appendix Z-1 letter to request a hearing in writing; in cases of decreasing or terminating services, members may retain their services at their current level by notifying DCH in writing within thirty

Options Using days of the Appendix Z-1 letter's date. Services remain in place pending the outcome of the Administrative Hearing.

(*Discharge to nursing home does not require a 30 day waiting period after the "Z" (Discharge, Termination) letter is sent; once Case Management decides it is appropriate to discharge the NH member from the Waiver, it is immediate. Refer to Section 1405-Involuntary Discharges*)

6. Case managers should follow up the Appendix Z-1 letter with a call within 15 days to determine if the member (or legal guardian if indicated) has any questions concerning the adverse action notice. (See Step 3 if member has not received notice)

7. If the member wishes to appeal, the case manager should assist with their request for a hearing as appropriate.

8. If the discharge was agency issued and the member appeals, a complete assessment packet is uploaded to AHS to maintain the Prior Authorization and maintain member services. The packet should be clearly identified as involuntary termination with appeal. (if AHS concurs, no new discharge notice is issued.)

9. The case manager should ensure the member has information on obtaining assistance in appealing an action (see Appendix Z-2 Notice of Your Right to a Hearing form).

10. The Case Manager will check with the member and/or family representative regarding the notice of adverse action and whether a hearing request has been filed with DCH before formally discharging the member from the program.

11. Members requesting discharge from SOURCE are exempt from the 30-day waiting period. Case managers should immediately send in a APPENDIX F form with the date requested for discharge by the member. The member will no longer receive SOURCE EPCCM or community based services as of the date indicated on the APPENDIX F. See also Policy No.1405 (a) Voluntary Discharge.

12. A SOURCE member has the right to represent him/herself or have an attorney, paralegal or any other person to represent him/her. Case managers should notify members of the availability of local services for legal assistance to older or low-income persons.

13. If an appeal is filed by the members, the site will present information at the appeal supporting the adverse action taken.

14. Additionally, the Interdisciplinary team, with the case manager, will view other resources to meet the member's needs. Appropriate discharge planning and referral assistance will be provided to the member by the case manager throughout the thirty-day notification period.

15. CM will notify member of the planned discharge and provide the member with information regarding the appeal process, as directed in Medicaid Part I Policy and Procedures section 500.

NOTE: Prior tp review by the Interdisciplinary team, the nurse (RN or LPN) shall review the member's diagnoses, medications, treatments with the member's PCP to ensure concurrence with Member's health and functional status as documented on the MDS-HC.

Procedures after decision of non-eligibility:

1. SOURCE assessment nurse (R.N. or LPN) will carry out the MDS HC assessment and the RN will make a preliminary determination if the member meets eligibility. If determined by the Case Management agency or AHS that the member does not meet eligibility, an appendix Z form will be sent to the member by the denial agency. The Appendix Z Form states why the member does not meet the LOC criteria and cites applicable policy. The member has thirty (30) days to request a hearing.

2. Discharge planning information/resources are sent to the member within 15 days of denial.

3. As of April 2016, AHS will reference a 2nd level review option on the discharge Appendix Z letter to members who have a AHS issued denial. This means that:

    a. If the member provides new information in the 10 days, they will either be accepted by AHS for LOC, or they will receive a 2nd and final denial letter.
    b. The member will have 10 business days to provide new information to AHS through their Case Management agency.
    c. If the member provides new information in the 10 days, they will either be accepted by AHS for LOC, or they will receive a 2nd and final denial letter.
    d. If the member does not give new information, no new denial letter will be issued from AHS. The member continues to have the right to ask for an appeal 30 days from issuance of the original denial letter

4. If the member requests a hearing, the member will send his/her hearing request to DCH Legal Services.

5. Upon receipt of the hearing request, DCH Legal Services will decide to accept or reject the request for hearing. If accepted DCH will:

6. Send the member a confirmation letter that the hearing will be granted and

7. Contact the SOURCE Program Site and /or AHS to request a copy of the file/records used to make the eligibility determination

8. Documentation of paperwork from steps 4 or 5, AHS confirmation, or a memo from DCH SOURCE confirming the hearing request was granted will confirm that Level of Care is to be continued under the DCH Legal Services authority (and services are to continue) for Utilization Review or Program Integrity.

9. SOURCE Program site or AHS will provide a copy of the records to DCH Legal Services.

10. The benefits must continue.

11. If member's Prior Authorization has expired, AHS will extend the LOC PA if they have denied the member. If this is an agency denial, Agency must upload reassessment packet to AHS with explanation that member is in appeal and needs a Prior Authorization number to continue benefits.

12. Upon receipt of the records, DCH Legal will assign the case to an attorney and transmit the case to OSAH for a hearing. OSAH will issue a notice of hearing setting a specific hearing date, time, and location.

13. While waiting for the hearing to occur, the benefits must continue, and reevaluations/ reassessments should occur if:
Greater than 9 months since last assessment
Approved by DCH.

14. During this waiting period, if the member decides that he/she does not want to proceed with the hearing, it is the member or the member's representative's duty to inform DCH And OSAH that the member no longer wishes to proceed with the hearing. SOURCE does not represent the member. SOURCE is not an agent of the state. The right to a hearing belongs to the member.

15. If the member decides to proceed with the hearing, the administrative hearing will occur and the administrative law judge will issue a decision. Continue member benefits pending the judge's decision.

16. If the judge rules in favor of DCH, the member's benefits will be reduced or terminated.
The member can appeal to the next level. Keep ruling with member file.

17. If the judge rules in favor of the member, the benefits will continue and DCH can appeal to the next level. Maintain a copy of the ruling with the most current Appendix F. Reference on the appendix F the court ruling. Annual Reassessment following an appeal is determined by the Prior Authorization dates. The time spent in hearing will count to the annual review.

Note: In the case of SOURCE terminations upheld through hearing, or in the case of voluntary terminations, SOURCE case management agencies notify all HCBS provider agencies involved in the provision of services to the member in order to avoid continuation of services not reimbursable under Medicaid.

1407. Confidentiality of Member Information

Integration of care for chronically ill people requires significant sharing of information between key players. To a greater extent than conventional HCBS, SOURCE Case Management Provider access, review and maintain patient records of all types, due to:

- Increased accountability standards for CM, across all treatment settings
- Coordination with participating primary medical care providers
- Formal linkages with health system providers

Ensuring appropriate access to medical and case management information by individuals involved in direct care or in monitoring care must be balanced with concern for member privacy. Offenses of confidentiality fall into two categories: unauthorized access of confidential data (looking at a member's chart or other data when there is no "need to know)," and the unauthorized use, dissemination or communication of clinical or other confidential data.

SOURCE Case Management Providers are required to act in accordance with the Health Insurance Portability and Accountability Act (HIPAA).

Procedures:

a) Each site will maintain a confidentiality policy specific to the organization.

b) The site-specific policy will include an "Employee Statement of Confidentiality" with disciplinary actions described for policy violations.

c) Upon admission, all members will sign a consent form to permit the release of information, as necessary to individuals or entities participating in the program.

d) Only case management, medical records and administrative staff will have direct access to member charts, excluding regulatory agency staff.

e) Charts will be maintained after hours in a secure environment.

f) Release of information to participating providers will be only on an as needed basis, and according to the policies and procedures of the site and DMA.

g) All charts will be maintained per the guidelines as specified in Part I Policies and Procedures for Medicaid/Peachcare for Kids.

1408. Non-Reimbursed Items and Services

In helping members continue residing in the community, CM will frequently discover needs for items or services not covered by conventional third-party payers like Medicaid or Medicare or by other traditional community resources. Often these items or services are critical to achieving Carepath outcomes for members, but the costs may be far out of reach for the member/caregiver to pay for privately. Sites will develop or have access to funds to bridge gaps in coverage for essential items or services. Typical examples include incontinence supplies, nutritional supplements and certain prescription medications; other examples are moving expenses, pest control, specific pieces of DME, etc.

If funds for non-covered items or services do not exist in the local community, a site may consider applying to local charitable foundations, accepting donations from civic organizations, individuals, churches and other faith-based organizations, etc., to build a fund. Sites must comply with all applicable local, state and federal requirements.

Payment for such items or services by the site does not set a precedent for such funding for all members. Consideration should be on an individual, case-by-case basis and will depend on the amount of funding and guidelines established.

Procedures:

a) The Case Manager will review any available options to cover a needed item or services, including the member/caregiver's own resources.

b) When other potential sources are ruled out, the Case Manager will submit a request in writing to the Case Manager Supervisor documenting specifically the service or item needed a time frame if applicable and a brief rationale.

c) The Case Manager Supervisor or Program Manager will have authority to approve the expenditure and will maintain a record of all items/services covered.

d) The Case Manager will forward the approved request to the organization or staff member (if internal) in charge of dispersing funds.

e) If the items/services are not approved, the Case Manager will continue to work with the SOURCE member/Caregiver to attempt to obtain the item or services from other sources or to find a suitable substitute.

f) For items/services funded on an ongoing basis, the Case Manager assigned will be responsible for reviewing every quarter the need for continued assistance.

g) Non-reimbursed services for members will be documented, for potential analysis of service packages.

1409. Due Process for SOURCE HCBS providers

SOURCE providers have the right to an Administrative Review should they be removed from a SOURCE Enhanced Case Management's Active Provider list of providers. Sites must notify providers in writing of the action. The provider shall have ten (10) days from the date of the written notice of removal from the DCH SOURCE referral list from the SOURCE Case Management Provider to submit a written request for the 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 Department of Community Health 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 Medicaid 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 SOURCE Active Provider list will be sent to the provider. If the provider wishes to appeal this determination regarding removal from the list, the provider may appeal the decision of the SOURCE Enhanced Case Management. The appeal must be in writing and received by the Commissioner'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 Commissioner'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 SOURCE action being appealed

A specific statement of why the provider believes the administrative review decision or other SOURCE action is wrong; and

- Submission of all documentation for review

An appeal shall state the action appealed.

The Department of Community Health and the Division of Medicaid will reach a decision within thirty (30) days of receiving the appeal. If the Commissioner's decision upholds that of the SOURCE Enhanced Case Management, removal from the SOURCE provider list shall remain in effect for the time specified.

The decision of the DCH Commissioner is final. No further appeal rights will be available to the provider.

1410. HIPAA Regulations

A federal law about health care, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), provides new health privacy regulations.

The Privacy Rule under HIPAA establishes privacy protections that assure Medicaid recipients and all health care patients that their medical records are kept confidential. The rules will help to ensure appropriate privacy safeguards are in place as we manage information technology to improve the quality of care provided to patients. The new protections give recipients greater access to their own medical records and more control over how their personal information is used by their health insurance plans (including Medicaid) and by health care providers.

The DCH Notice of Privacy Practices explains how Georgia Medicaid uses and discloses individuals' health information and how individuals may access their information. The notice was mailed to all Medicaid recipients with the April 2004 eligibility cards.

1411. SOURCE Sentinel Event Policy

Case Managers will complete the SOURCE Sentinel Event Report in the event of an unanticipated incident that results in death or significant physical, financial or emotional injury of a SOURCE member. Excluded are deaths, injuries or impairments due to acute illness that can be reasonably considered a potential outcome in consideration of a member's age or health status. These are not events that occur in a hospital or rehabilitation facility.

Reportable Sentinel events include:

:

- Falls
- Significant physical injuries
- Alleged criminal acts by staff against a member
- Alleged criminal acts which are reported to the police by a person who receives services
- Member 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 member 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 member
- 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
- Inadequate assistance with personal care, changing bed linen, laundry, etc.
- Leaving member alone for long periods of time
- Failure to provide basic care or seek medical care

Procedures:

1. In the event of a sentinel event, the Case Manager will complete the Sentinel Event Report (see Appendix for form), in consultation with the Case Management supervisor.

2. The SOURCE PCP or Medical Director will also be consulted as indicated, to accurately complete the report.

3. Sites shall notify the DCH SOURCE Program Specialist of all sentinel events, by email within 24 hours and send the completed Sentinel Event Form within 5 business days.

4. Again, in consultation with the Case Management supervisor, the Case Manager will implement follow-up activities indicated.

1413. Case Management Reimbursement Hierarchy

Note: Duplication of Case Management Services

Federal policy and the Department of Community Health (DCH) prohibit the reimbursement for repetitive case management services to more than one agency or Medicaid provider that renders case management services to an individual. (Guidelines for dual enrollment in SOURCE and acceptable non-repetitive Case Management are in section 701 Member Exclusions)

- A hierarchy (see below) for case management services was established to prevent payment of more than one case management services per month.
  1. COS 830 – CMO
  2. COS 851 – SOURCE CM (COS 851 ends 10/1/2015)
  3. COS 680 - MRWP/NOW
  4. COS 681 - CHSS/COMP
  5. COS 660 – ICWP
  6. COS 590 – CCSP
  7. COS 764 – Child Protective Services Targeted Case management
  8. COS 800 – Early Intervention Case Management
  9. COS765 – Adult Protective Services Targeted Case Management
  10. COS763 – At Risk of Incarceration Targeted Case Management
  11. COS762 – Adults with AIDS Targeted Case Management
  12. COS790 – Rehab Services/DSPS
  13. COS100 – Dedicated Case Management – Non-Waiver Members
  14. COS840 – Children's Intervention Services

Effective for dates of service on and after January 1, 2009, the Case Management agency or Medicaid Provider submitting claims for the same member in the same calendar month:

- If two claims are submitted for CM services the hierarchy determines which provider will be paid.
- If the lower hierarchy provider has been reimbursed the claim amount will be recovered and payment made to the CM provider first in the hierarchy.

1414.0 Conflict Free Case Management

The Balancing Incentive Program (BIP), authorized by Section 10202 of the 2010 Affordable Care Act (ACA), is being transitioned into Georgia. BIP aims to improve access to community-based long-term services and supports (LTSS).BIP includes Conflict-Free Case Management (CFCM).

How this affects SOURCE Case Management Agencies:

As a care/case management entity, you are required to adhere to the following characteristics of conflict-free case management:

- *Separation of case management from direct services*: Structurally or operationally, care coordinators should not be employees of any organization that provides direct services to the individuals. Ideally, conflict-free case management agencies are stand-alone and provide no other direct services. This prevents financial pressure for care coordinators to make referrals to their own organization or "trade" referrals.

- *Separation of eligibility determination from direct services*: Eligibility for services is established separately from the provision of services so assessors do not feel pressure to make individuals eligible to increase business for their organization. Eligibility is determined by an entity or organization that has no fiscal relationship to the individual. In our system, this occurs through the level-of-care determination process.

- *Case managers do not establish funding levels for the individual:* In the Georgia model, the care coordinator/manager's responsibility is to develop a recommended plan of supports and services based on the individual's assessed needs. Ultimately, DCH staff and its agent (AHS/Alliant) will determine whether the care plan is medically necessary.

  (For SOURCE, funding level is set by the waiver, and individual funding is ultimately under the approval of DCH for medical necessity, this will be reinforced with training to Case Management Agencies.)

- *Individuals performing evaluations, assessments and plans of care cannot be* related by blood or marriage to the individual or any of the individual's paid caregivers, or financially responsible for the individual.

A plan from each care management entity that identifies its strategies for conflict-free case management should be included in all company policy manuals.

If you feel your agency is the only provider supplying care coordination and direct support services for an area, please notify DCH for further direction.

If DCH agrees, you will need to identify the protections that are engaged to mitigate conflicts of interest. Each plan should also speak to the development of a written protocol that would be applied operationally to support the adherence to policy.

Georgia Families

Georgia Families® (GF) is a statewide program designed to deliver health care services to members of Medicaid, PeachCare for Kids®, and Planning for Healthy Babies® (P4HB) recipients. The program is a partnership between the Department of Community Health (DCH) and private care management organizations (CMOs). By providing a choice of health plans, Georgia Families allows members to select a health care plan that fits their needs.

It is important to note that GF is a full-risk program; this means that the four CMOs licensed in Georgia to participate in GF are responsible and accept full financial risk for providing and authorizing covered services. This also means a greater focus on case and disease management with an emphasis on preventative care to improve individual health outcomes.

The four licensed CMOs:

Amerigroup Community Care 1-800-454-3730 www.amerigroup.com	CareSource 1-855-202-1058 www.caresource.com
Peach State Health Plan 866-874-0633 www.pshpgeorgia.com	WellCare of Georgia 866-231-1821 www.wellcare.com

Children, parent/caretaker with children, pregnant women and women with breast or cervical cancer on Medicaid, as well as children enrolled in PeachCare for Kids® are eligible to participate in Georgia Families. Additionally, Planning for Healthy Babies® (P4HB) recipients receive services through Georgia Families® (GF). Children in foster care or receiving adoption assistance and certain youths committed to juvenile justice are enrolled in Georgia Families 360°.

Eligibility Categories for Georgia Families:

Included Populations	Excluded Populations
Parent/Caretaker with Children	Aged, Blind and Disabled
Transitional Medicaid	Nursing home
Pregnant Women (Right from the Start Medicaid – RSM)	Long-term care (Waivers, SOURCE)
Children (Right from the Start Medicaid – RSM)	Federally Recognized Indian Tribe
Children (newborn)	Georgia Pediatric Program (GAPP)
Women Eligible Due to Breast and Cervical Cancer	Hospice
PeachCare for Kids®	Children's Medical Services program
Parent/Caretaker with Children	Medicare Eligible
Children under 19	Supplemental Security Income (SSI) Medicaid
Women's Health Medicaid (WHM)	Medically Needy
Refugees	Recipients enrolled under group health plans
Planning for Healthy Babies®	Individuals enrolled in a Community Based Alternatives for Youths (CBAY)

Resource Mothers Outreach	

Medicaid and PeachCare for Kids® members will continue to be eligible for the same services they receive through traditional Medicaid and state Value Added Benefits. Members will not have to pay more than they paid for Medicaid co-payments or PeachCare for Kids® premiums. With a focus on health and wellness, the CMOs will provide members with health education and prevention programs giving them the tools needed to live healthier lives. Providers participating in Georgia Families will have the added assistance of the CMOs to educate members about accessing care, referrals to specialists, member benefits, and health and wellness education. **All four CMOs are State-wide.**
The Department of Community Health has contracted with four CMOs to provide these services:

- Amerigroup Community Care
- CareSource
- Peach State Health Plan
- WellCare of Georgia

Members can contact Georgia Families for assistance to determine which program best fits their family's needs. If members do not select a plan, Georgia Families will select a health plan for them.
Members can visit the Georgia Families Web site at www.georgia-families.com or call 1-800-GA-ENROLL (1-888-423-6765) to speak to a representative who can give them information about the CMOs and the health care providers.
The following categories of eligibility are included and excluded under Georgia Families:
Included Categories of Eligibility (COE):

COE	DESCRIPTION
104	LIM – Adult
105	LIM – Child
118	LIM – 1st Yr Trans Med Ast Adult
119	LIM – 1st Yr Trans Med Ast Child
122	CS Adult 4 Month Extended
123	CS Child 4 Month Extended
135	Newborn Child
170	RSM Pregnant Women
171	RSM Child
180	P4HB Inter Pregnancy Care
181	P4HB Family Planning Only
182	P4HB ROMC - LIM
183	P4HB ROMC - ABD
194	RSM Expansion Pregnant Women
195	RSM Expansion Child < 1 Yr
196	RSM Expn Child w/DOB < = 10/1/83
197	RSM Preg Women Income < 185 FPL
245	Women's Health Medicaid
471	RSM Child
506	Refugee (DMP) – Adult
507	Refugee (DMP) – Child
508	Post Ref Extended Med – Adult
509	Post Ref Extended Med – Child
510	Refugee MAO – Adult
511	Refugee MAO – Child
571	Refugee RSM - Child
595	Refugee RSM Exp. Child < 1
596	Refugee RSM Exp Child DOB </= 10/01/83
790	Peachcare < 150% FPL
791	Peachcare 150 – 200% FPL

792	Peachcare 201 – 235% FPL
793	Peachcare > 235% FPL
835	Newborn
836	Newborn (DFACS)
871	RSM (DHACS)
876	RSM Pregnant Women (DHACS)
894	RSM Exp Pregnant Women (DHACS)
895	RSM Exp Child < 1 (DHACS)
897	RSM Pregnant Women Income > 185% FPL (DHACS)
898	RSM Child < 1 Mother has Aid = 897 (DHACS)
918	LIM Adult
919	LIM Child
920	Refugee Adult
921	Refugee Child

Excluded Categories of Eligibility (COE):

COE	DESCRIPTION
124	Standard Filing Unit – Adult
125	Standard Filing Unit – Child
131	Child Welfare Foster Care
132	State Funded Adoption Assistance
147	Family Medically Needy Spend down
148	Pregnant Women Medical Needy Spend down
172	RSM 150% Expansion
180	Interconceptional Waiver
210	Nursing Home – Aged
211	Nursing Home – Blind
212	Nursing Home – Disabled
215	30 Day Hospital – Aged
216	30 Day Hospital – Blind
217	30 Day Hospital – Disabled
218	Protected Med/1972 Cola - Aged
219	Protected Med/1972 Cola – Blind
220	Protected Med/1972 Cola - Disabled
221	Disabled Widower 1984 Cola - Aged
222	Disabled Widower 1984 Cola – Blind
223	Disabled Widower 1984 Cola – Disabled
224	Pickle - Aged
225	Pickle – Blind
226	Pickle – Disabled
227	Disabled Adult Child - Aged
227	Disabled Adult Child - Aged
229	Disabled Adult Child – Disabled
230	Disabled Widower Age 50-59 – Aged
231	Disabled Widower Age 50-59 – Blind
232	Disabled Widower Age 50-59 – Disabled
233	Widower Age 60-64 – Aged
234	Widower Age 60-64 – Blind
235	Widower Age 60-64 – Disabled
236	3 Mo. Prior Medicaid – Aged

237	3 Mo. Prior Medicaid – Blind
238	3 Mo. Prior Medicaid – Disabled
239	Abd Med. Needy Defacto – Aged
240	Abd Med. Needy Defacto – Blind
241	Abd Med. Needy Defacto – Disabled
242	Abd Med Spend down – Aged
243	Abd Med Spend down – Blind
244	Abd Med Spend down – Disabled
246	Ticket to Work
247	Disabled Child – 1996
250	Deeming Waiver
251	Independent Waiver
252	Mental Retardation Waiver
253	Laurens Co. Waiver
254	HIV Waiver
255	Cystic Fibrosis Waiver
259	Community Care Waiver
280	Hospice – Aged
281	Hospice – Blind
282	Hospice – Disabled
283	LTC Med. Needy Defacto – Aged
284	LTC Med. Needy Defacto –Blind
285	LTC Med. Needy Defacto – Disabled
286	LTC Med. Needy Spend down – Aged
287	LTC Med. Needy Spend down – Blind
288	LTC Med. Needy Spend down – Disabled
289	Institutional Hospice – Aged
290	Institutional Hospice – Blind
291	Institutional Hospice – Disabled
301	SSI – Aged
302	SSI – Blind
303	SSI – Disabled
304	SSI Appeal – Aged
305	SSI Appeal – Blind
306	SSI Appeal – Disabled
307	SSI Work Continuance – Aged
309	SSI Work Continuance – Disabled
308	SSI Work Continuance – Blind
315	SSI Zebley Child
321	SSI E02 Month – Aged
322	SSI E02 Month – Blind
323	SSI E02 Month – Disabled
387	SSI Trans. Medicaid – Aged
388	SSI Trans. Medicaid – Blind
389	SSI Trans. Medicaid – Disabled
410	Nursing Home – Aged
411	Nursing Home – Blind
412	Nursing Home – Disabled
424	Pickle – Aged
425	Pickle – Blind
426	Pickle – Disabled
427	Disabled Adult Child – Aged

428	Disabled Adult Child – Blind
429	Disabled Adult Child – Disabled
445	N07 Child
446	Widower – Aged
447	Widower – Blind
448	Widower – Disabled
460	Qualified Medicare Beneficiary
466	Spec. Low Inc. Medicare Beneficiary
575	Refugee Med. Needy Spend down
660	Qualified Medicare Beneficiary
661	Spec. Low Income Medicare Beneficiary
662	Q11 Beneficiary
663	Q12 Beneficiary
664	Qua. Working Disabled Individual
815	Aged Inmate
817	Disabled Inmate
870	Emergency Alien – Adult
873	Emergency Alien – Child
874	Pregnant Adult Inmate
915	Aged MAO
916	Blind MAO
917	Disabled MAO
983	Aged Medically Needy
984	Blind Medically Needy
985	Disabled Medically Needy

HEALTH CARE PROVIDERS

For information regarding the participating health plans (enrollment, rates, and procedures), please call the numbers listed below.

Prior to providing services, you should contact the member's health plan to verify eligibility, PCP assignment and covered benefits. You should also contact the health plan to check prior authorizations and submit claims.

Amerigroup Community Care	**CareSource**	**Peach State Health Plan**	**WellCare of Georgia**
800-454-3730 (general information) www.amerigroup.com	1-855-202-1058 www.careSource.com/GeorgiaMedicaid	866-874-0633 (general information) 866-874-0633 (claims) 800-704-1483 (medical management) www.pshpgeorgia.com	866-231-1821 www.wellcare.com

Registering immunizations with GRITS:

If you are a Vaccine for Children (VFC) provider, please continue to use the GRITS (Georgia Immunization Registry) system for all children, including those in Medicaid and PeachCare for Kids®, fee-for-service, and managed care.

Important tips for the provider to know/do when a member comes in:

Understanding the process for verifying eligibility is now more important than ever. You will need to determine if the patient is eligible for Medicaid/PeachCare for Kids® benefits and if they are enrolled in a Georgia Families health plan. Each plan sets its own medical management and referral processes.

Members will have a new identification card and primary care provider assignment.
You may also contact DXC at 1-800-766-4456 (statewide) or www.mmis.georgia.gov for information on a member's health plan.

Use of the Medicaid Management Information System (MMIS) web portal:

The call center and web portal will be able to provide you information about a member's Medicaid eligibility and health plan enrollment. DXC will **not** be able to assist you with benefits, claims processing or prior approvals for members assigned to a Georgia Families health plan. You will need to contact the member's plan directly for this information.

Participating in a Georgia Families' health plan:

Each health plan will assign provider numbers, which will be different from the provider's Medicaid provider number and the numbers assigned by other health plans.

Billing the health plans for services provided:

For members who are in Georgia Families, you should file claims with the member's health plan.

If a claim is submitted to DXC in error:

DXC will deny the claim with a specific denial code. Prior to receiving this denial, you may go ahead and submit the claim to the member's health plan.

Credentialing

Effective August 1, 2015, Georgia's Department of Community Health (DCH) implemented a NCQA certified Centralized Credentialing Verification Process utilizing a Credentialing Verification Organization (CVO). This functionality has been added to the Georgia Medicaid Management Information System (GAMMIS) website (www.MMIS.georgia.gov) and has streamlined the time frame that it takes for a provider to be fully credentialed.

Credentialing and recredentialing services is provided for Medicaid providers enrolled in Georgia Families and/or the Georgia Families 360° program.

This streamlined process results in administrative simplification thereby preventing inconsistencies, as well as the need for a provider to be credentialed or recredentialed multiple times.

The CVO's one-source application process:

- Saves time
- Increases efficiency
- Eliminates duplication of data needed for multiple CMOs
- Shortens the time period for providers to receive credentialing and recredentialing decisions

The CVO will perform primary source verification, check federal and state databases, obtain information from Medicare's Provider Enrollment Chain Ownership System (PECOS), check required medical malpractice insurance, confirm Drug Enforcement Agency (DEA) numbers, etc. A Credentialing Committee will render a decision regarding the provider's credentialing status. Applications that contain all required credentialing and recredentialing materials at the time of submission will receive a decision within 45 calendar days. Incomplete applications that do not contain all required credentialing documents will be returned to the provider with a request to supplement all missing materials. Incomplete applications may result in a delayed credentialing or recredentialing decision. The credentialing decision is provided to the CMOs.

HP provider reps will provide training and assistance as needed. Providers may contact HP for assistance with credentialing and recredentialing by dialing 1-800-766-4456.

Assignment of separate provider numbers by all of the health plans:

Each health plan will assign provider numbers, which will be different from the provider's Medicaid provider number and the numbers assigned by other health plans.

Billing the health plans for services provided:

For members who are in Georgia Families, you should file claims with the member's health plan.

If a claim is submitted to DXC in error:

DXC will deny the claim with a specific denial code. Prior to receiving this denial, you may go ahead and submit the claim to the member's health plan.

Receiving payment:

Claims should be submitted to the member's health plan. Each health plan has its own claims

processing and you should consult the health plan about their payment procedures.

Health plans payment of clean claims:

Each health plan (and subcontractors) has its own claims processing and payment cycles. The claims processing and payment timeframes are as follows:

Amerigroup Community Care	**CareSource**	**Peach State Health Plan**	**WellCare of Georgia**
Amerigroup runs claims cycles twice each week (on Monday and Thursday) for **clean** claims that have been adjudicated. Monday Claims run: Checks mailed on Tuesday. Providers enrolled in ERA/EFT receive the ACH on Thursday. Thursday Claims run: Checks mailed on Wednesday. Providers enrolled in ERA/EFT receive the ACH on Tuesday. **Dental:** Checks are mailed weekly on Thursday for **clean** claims. **Vision**: Checks are mailed weekly on Wednesday for **clean** claims (beginning June 7th) **Pharmacy**: Checks are mailed to pharmacies weekly on Friday (except when a holiday falls on Friday, then mailed the next business day)	CareSource runs claims cycles twice each week on Saturdays and Tuesdays for clean claims that have been adjudicated. Pharmacy: Payment cycles for pharmacies is weekly on Wednesdays.	Peach State has two weekly claims payment cycles per week that produces payments for **clean** claims to providers on Monday and Wednesday. For further information, please refer to the Peach State website, or the Peach State provider manual.	WellCare runs claims payment cycles up to six (6) times each week for **clean** claims. For further information, please refer to the WellCare website, the WellCare provider manual, or contact Customer Service at 866-231-1821

How often can a patient change his/her PCP?

Amerigroup Community Care	**CareSource**	**Peach State Health Plan**	**WellCare of Georgia**
Anytime	Members can change their PCP one (1) time	Within the first 90 days of a member's	Members can change PCPs for any reason

	per month. However, members can change their PCP at any time under extenuating circumstances such as: • Member requests to be assigned to a family member's PCP • PCP does not provide the covered services a member seeks due to moral or religious objections • PCP moves, retires, etc.	enrollment, he/she can change PCP monthly. If the member has been with the plan for 90 days or longer, the member can change PCPs once every six months. There are a few exclusions that apply and would warrant an immediate PCP change.	within the first 90 days of their enrollment. After the first 90 days, members may change PCPs once every six months.

Once the patient requests a PCP change, how long it takes for the new PCP to be assigned:

Amerigroup Community Care	**CareSource**	**Peach State Health Plan**	**WellCare of Georgia**
Next business day	PCP selections are updated in CareSource's systems daily.	PCP changes made before the 24th day of the month and are effective for the current month. PCP changes made after the 24th day of the month are effective for the first of the following month.	PCP changes made between the 1st and 10th of the month will go into effect right away. Changes made after the 10th of the month will take effect at the beginning of the next month

PHARMACY

Georgia Families does provide pharmacy benefits to members. Check with the member's health plan about who to call to find out more about enrolling to provide pharmacy benefits, including information about their plans reimbursement rates, specific benefits that are available, including prior approval requirements.

To request information about contracting with the health plans, you can call the CMOs provider enrollment services.

Amerigroup Community Care	**CareSource**	**Peach State Health Plan**	**WellCare of Georgia**
800-454-3730 https://providers.amerigroup.com/pages/ga-2012.aspx	844-441-8024 https://cvs.az1.qualtrics.com/jfe/form/SV_cvyY0ohqT2VXYod	866-874-0633 www.pshpgeorgia.com	866-300-1141 ProspectiveProviderGA@WellCare.com or https://www.wellcare.com/en/Georgia/Become-a-Provider

All providers must be enrolled as a Medicaid provider to be eligible to contract with a health plan to provide services to Georgia Families members.

The CMO Pharmacy Benefit Managers (PBM) and the Bin Numbers, Processor Control Numbers and Group Numbers are:

Health Plan	PBM	BIN #	PCN
Amerigroup Community Care	ESI	003858	MA
CareSource	CVS Caremark	004336	MCAIDADV Group: RX0835
Peach State Health Plan	US Script (PBM) Caremark (Claims Processor)	004336	MCAIDADV
WellCare of Georgia	Caremark	004336	MCAIDADV

If a patient does not have an identification card:

Providers can check the enrollment status of Medicaid and PeachCare for Kids® members through DXC by calling 1-800-766-4456 or going to the web portal at www.mmis.georgia.gov. DXC will let you know if the member is eligible for services and the health plan they are enrolled in. You can contact the member's health plan to get the member's identification number.

Use of the member's Medicaid or PeachCare for Kids® identification number to file a pharmacy claim:

Amerigroup Community Care	CareSource	Peach State Health Plan	WellCare of Georgia
No, you will need the member's health plan ID number	Yes, you may also use the health plan ID number.	Yes	Yes, you may also use the WellCare subscriber ID

Health plans preferred drug list, prior authorization criteria, benefit design, and reimbursement rates: Each health plan sets their own procedures, including preferred drug list, prior authorization criteria, benefit design, and reimbursement rates.

Will Medicaid cover prescriptions for members that the health plans do not?

No, Medicaid will not provide a "wrap-around" benefit for medications not covered or approved by the health plan. Each health plan will set its own processes for determining medical necessity and appeals.

Who to call to request a PA:

Amerigroup Community Care	CareSource	Peach State Health Plan	WellCare of Georgia
1 (800) 454-3730	1 (855) 202-1058 1(866) 930-0019 (fax)	1 (866) 399-0929	1 (866) 231-1821 1 (866) 455-6558 (fax)