
REQUIRED CARE MANAGEMENT CONTACTS

☞ PURPOSE OF REQUIRED CONTACTS

The care management contact requirements were developed to assure that the care manager has regular and ongoing contact with the program participant and key caregivers. These contacts are an opportunity for the care manager to develop a relationship with the participant. They provide an opportunity for the care manager to reassess the participant's needs, monitor the efficacy of the care plan, resolve problems that arise, and provide support to the participant.

☞ CONTACT REQUIREMENTS

The care manager is responsible for making the required contacts and documenting them in the case file. A tool for planning care management contacts is provided in this section. The required contacts are as follows. **Note: Care managers can bill for time spent completing case notes, but this is not considered a care management contact.**

During the first 30 days:

- At a minimum, care managers must have direct contact (face-to-face or by telephone) with the participant *and* with a provider agency, caregiver, or some other person who is significant in the care plan within the first 30 days after the waiver program start date. No exceptions are allowed. Important note: Required care management contacts occur after the waiver start date and DOES NOT include the initial assessment or plan development contacts.

After the first 30 days:

- Direct participant contacts *or* collateral contacts are required monthly. Direct participant contacts include telephone, written, e-mail or voice mail **exchange** with the participant, or face-to-face contacts. A collateral contact includes written, telephone, fax, or face-to-face contact with the participant's family member, medical or social service provider, or other person with knowledge of the participant's long term care needs. It can also be a written e-mail or voice mail **exchange** with the participant's medical or social service provider, or other person with knowledge of the participant's long term care needs. Important note: collateral contacts **do not** include the mailing or fax transmissions or other exchange of documents required for certification or recertification.

- Face-to-face contact is required with the participant every three months. At least one of the face-to-face contacts must occur within the participant's residence. To assure health and safety, more frequent face-to-face contacts may be necessary.
- Every six months, the care manager shall review the plan of care during a face-to-face contact with the waiver participant. No exceptions are permitted. In the event the participant has been adjudicated incompetent, the 6-month review may be conducted with his/her guardian. However the care manager must continue to make the required face-to-face contacts with the participant and must involve the participant in the plan development process, to the extent he/she is able to participate.

DETERMINING THE FREQUENCY OF CONTACTS

Determinations of the types and frequency of contacts with participants, caregivers, and providers must be based on the following criteria:

- Stability or frailty of the participant's health.
- Ability of the participant to direct his or her own care.
- Strength of in-home supports and the participant's informal support network.
- Stability of in-home care staff (e.g., frequency and reliability of staffing, historical frequency of turnover, availability of emergency back-up).
- Stability of the participant's care plan (e.g., historical and/or anticipated frequency of changes or adjustments to the plan).
- The participant has lived in the community without a critical incident or EA/APS referral for three years
- If applicable, the participant has an active and interested guardian who is **not** a waiver service provider.

EXCEPTIONS TO THE MINIMUM REQUIREMENTS

Persons who participate in the waiver program, have complex health and service needs. Consequently, waiver participants usually need active care management to implement, monitor, and reassess their care plans. It is anticipated that most participants will require more contact than that described in the minimum requirements. If the appropriate type and frequency of care management contact is less than the minimum requirements, all supporting documentation must be included in the participant's file.

If a waiver participant requests less face-to-face care management contact, the manual describes a process for documenting this. It is very important that the care manager document this process thoroughly in the participant's file. **Please note that this exception specifically excludes participants who live in licensed or certified facilities such as Adult Family Homes (AFH), Community-Based Residential Facilities (CBRFs), independent apartment CBRFs, or Residential Care Apartment Complexes (RCACs). Evidence that the participant resides in his or her own home or apartment must be documented in the participant's file.**

The exception process is described below. It is expected that it will be used **infrequently**. (Note: care management **must** be provided at least once per month for the first six months the participant is in the program.)

1. Participant and/or the participant's guardian ask for the frequency of care management contacts to be decreased.

Evidence that the participant, or participant's guardian, or family **requested** a reduction in the face-to-face care management contacts, including the date the request was made and the reason the participant or guardian gave for making the request must be documented in the participant's file. Note: the signature/date of the participant or guardian must be obtained.

2. The care manager applies the 7 criteria outlined on the previous page.
3. The care manager and supervisor review the participant's request and the application of the above criteria to determine if the required face-to-face care management contacts can be exempted.
 - Evidence that the request is agreed to by the care manager and approved by the care management supervisor must be documented in the participant's file.
 - A description of how the participant's health, safety and welfare will be assured in the absence of the required contacts.
 - A description of the contacts that will occur.
4. The care management contact plan **must be reviewed with the participant every 12 months** as part of the service plan review. If the participant continues to request less face-to-face care management contact than required by the waiver program, the criteria must be reviewed again. **Documentation must also include the participant's signed agreement to the minimum face-to-face contact exception, every 12 months.**
5. The care management contact plan can be reviewed and changed at any time. Any changes to the plan can be initiated by the participant or the care manager.

IMPORTANT INFORMATION: The exception to the contact requirement applies only to contacts between the care manager and the participant. Required collateral contacts must continue for ongoing monitoring.

An exception to the required contacts **may not** be made for the 6-month face-to-face plan review.

The following are examples of **unacceptable** documentation in the participant's file:

- An ISP that reads: "care management contact as needed" that is signed by the participant, care manager, and supervisor.
- A case note that reads: "care management requested every six months."

- Any kind of written "sign off" that does not include all the points and criteria listed in the Medicaid Waivers Manual.
- A case note that reads: "care management contacts have been waived by the participant and this has been approved by the care manager and supervisor."

A model form that can be used to document the process outlined above is available at:

<http://dhfs.wisconsin.gov/forms1/DDES/dde1063.doc>

Documentation of this process will be reviewed during waiver monitoring.

Case notes explaining how each of the variables listed in the Medicaid Waivers Manual have been applied must be included in the participant's file.

NOTES

KEY

R = Recertification
S = Service Plan Review
F = Face-to-Face Contact
D = Direct Contact
C = Collateral Contact

Direct participant contact or collateral contact is required monthly.

Face-to-face participant contact is required every three months.

Every six months, the care manager must review the plan of care during a face-to-face contact with the waiver participant.

Direct contact with participants requires an *exchange* between the participant and the care manager via face-to-face contact, telephone contact, voice mail, or e-mail exchanges. The emphasis on exchange is important to note. If information is sent to or received by a participant but no response is received, there is no guarantee that the participant either received or understood the information relayed. To ensure that participants receive and understand information, an *exchange* must occur between the care manager and the participant that acknowledges the contact. Direct contact does not include written correspondences between the care manager and the participant (e.g. faxes or letters).

Collateral contact includes written, telephone, or face-to-face contact with the participant's family members, medical or social service providers, or other persons with knowledge of the participant's long term care needs.

Regarding "new" ways in which to communicate, the following applies:

E-mails

- If a care manager *exchanges* e-mail with a participant or a guardian, it would be considered a direct contact (similar to a phone call).
- If a care manager *exchanges* e-mail with a provider, family member, or others knowledgeable about the participant's case, it would be considered a collateral contact (similar to a phone call).

Faxes

- If a care manager *sends* a fax to a participant or a guardian, this is **not** considered a care management contact. However, please note that this is billable care management time.
- If a care manager *receives* a fax from a participant or a guardian this is **not** considered a care management contact.
- If a care manager either sends or receives a fax to a provider, it would be considered a collateral contact.

Voice Mail

- If a care manager *receives* a voice mail from a participant or his/her guardian in which relevant, case-specific information is relayed, **and** the care manager *responds* to the voice mail, this would be considered a direct contact (similar to a phone call).
- If a care manager *leaves* a voice mail relaying relevant, case-specific information on a participant or guardian's phone, **and** the participant *responds* to the voice mail, this would be considered a direct contact.
- If a care manager either receives from or leaves a voice mail on a provider's phone (i.e. SHC coordinator, AFH sponsor, etc), this would be considered a collateral contact.

It is best practice for the specific information that is being shared/exchanged during the message to be well documented within the case notes.

At a minimum, care managers must have contact (face-to-face or telephone) with the participant and with a provider agency, caregiver, or some other person who is significant in the care plan within the first 30 days of the beginning of Medicaid waiver-funded services.

EXCEPTION TO CARE MANAGEMENT / SUPPORT AND SERVICE COORDINATION CONTACT REQUIREMENTS

All sections must be filled out completely and the form must be signed and dated by the participant (or guardian), care manager/support and service coordinator and supervisor to meet exception to contact requirements. Use of this form is optional.

Name of Participant (Last, First, MI)

Date of Request

Please answer the following questions. If the answer is "Yes," continue. If you answer "No" to any of the questions, STOP. An exception to care management/support and service coordinator contacts cannot be granted.

Did the participant/guardian request this exception?

Yes

No

Has at last six months passed since the participant's initial plan approval?

Yes

No

Does the participant reside in his/her own home or apartment?

Yes

No

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1. Describe change in face-to-face care management/support and service coordination contacts requested by participant and the reasons the participant gave for making the request. (As a reminder, the six-month review of the service plan must occur during a face-to-face visit—there are no exceptions to this requirement.)

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2. Describe how the variables listed below would affect the frequency of care management/support and service coordination contact needed by the participant.

a. Stability or frailty of the participant's health:

b. Ability of the participant to direct his or her own care:

c. Strength of in-home supports and the participant's informal support network:

- d. Stability of in-home care staff (e.g., historical frequency of turnover, availability of emergency back-up):

- e. Stability of the participant's care plan (e.g., historical and/or anticipated frequency of changes or adjustments to the plan):

- f. If applicable, the participant has lived in the community without EA/APS or critical incident for three years.

- g. If applicable, the participant has an active and interested guardian who is not a waiver service provider.

3. Based on information in numbers 1 and 2 above, it is determined that care management contacts can be less than required by the waiver program. Care management/support and service coordination will be provided in the following way (describe who will provide services and frequency of contact):

SIGNATURE – Participant or Guardian	Date Signed
SIGNATURE – Care Manager/Support and Service Coordinator	Date Signed
SIGNATURE – Supervisor	Date Signed

The participant can reconsider the exemption from care management contacts at any time, but this request must be formally reviewed with the participant, care manager/support and service coordinator and supervisor, and a new form completed, every 12 months.

CASE NOTES

- All care management contacts; or changes in frequency or type of service provided to the participant (including the reason for the change) must be recorded in a case note.
- A case note should accomplish the following:
 - 1) Describe the event, (e.g. a phone call, home visit, writing a correspondence)
 - 2) Cite the date
 - 3) Identify the people involved and their relationship to the participant
 - 4) Recount the transaction
 - 5) Demonstrate how the contact relates to the participant's service plan or an outcome
 - 6) Describe the outcome of the contact

Samples:

10/1/08 Received phone call from Mrs. Smith's daughter, Mary Rhoades. Mary requested additional supportive home care services for her mom (Mrs. Smith). Mary will be out of town from October 3-11, 2008 and will not be able to do Mrs. Smith's grocery shopping for her, as is her usual routine. Mary relayed that she usually takes Mrs. Smith grocery shopping on Monday mornings, so if this additional service could be provided on that day, Mary felt this would be helpful to her mom. However, Mary also relayed she would understand if scheduling problems prohibited this from occurring. Sally J. Brown, care manager

10/1/08 Phone call to Work-4-U agency. Spoke with Joanne Hill, the SHC Coordinator, and arranged for two additional hours of SHC to do the grocery shopping. Relayed preference of doing grocery shopping on Monday morning if at all possible. Joanne said she would see what she could do and get back to this care manager. Additional SHC hours will be funded by COP-W. Sally J. Brown, care manager

10/1/08 Received phone call from Joanne Hill, SHC Coordinator. She relayed that a SHC worker will be able to take Mrs. Smith grocery shopping on Monday, October 6, 2008 at 9:30 a.m. Told Joanne that I would inform Mrs. Smith's daughter. Sally J. Brown, care manager

10/1/08 CM called Mary Rhoades back and informed her that additional hours have been arranged for Monday, October 6th to take Mrs. Smith grocery shopping. Informed Mary that the SHC worker would arrive at 9:30 a.m. Mary said she would let her mom (Mrs. Smith) know about the arrangements. Mary expressed her appreciation. Sally J. Brown, care manager

NOTES

SERVICE REVIEWS

☞ PURPOSE OF SERVICE REVIEWS

The service plan should be reviewed regularly to ensure it continues to meet the needs and preferences of the participant. It is also an opportunity to review the identified outcomes and review the status of each.

☞ CONDUCTING A SERVICE REVIEW

At a minimum, the service plan must be reviewed **every six months during a face-to-face contact with the participant**. The transaction and related outcomes from the service review should be recorded in a case note and services should be arranged as needed. The ISP should be updated if necessary (see ISP Updates for more information). In the event the participant has a guardian, the six-month plan review may be conducted with the guardian. However, the care manager must continue to make the required face-to-face contacts with the participant and involve the participant in the plan development process to the extent the participant is able to participate.

The six-month review can be documented in the following ways:

- 1) The participant can re-sign and date the ISP.
- 2) A case note can be inserted within the record to illustrate the review took place. Here is an example of a six-month service plan review in case note form

10-17-08 *Home visit with Mrs. Brown for purpose of conducting a 6-month review of her ISP. Mrs. Brown said she was feeling good. Hasn't had to see the doctor for the past 2 months. Said she hasn't had any more dizzy spells and is starting to sleep through the night again. Mrs. Brown was appropriately dressed and seemed in good spirits. She said she spent Sunday (10-12-08) with her son (Tom), daughter-in-law and grandchildren. Had a lovely time. We reviewed the ISP. Mrs. Brown feels the 4 hours of supportive home care a week from Helpers, Unlimited continues to meet her needs. She said her worker, Beth Adams, continues to do a good job - always on time, very reliable. Beth works on Tuesdays beginning 1:30 p.m. - Mrs. Brown said this schedule is working out fine - no desire for a change. We discussed her PERS. She said she feels "safer knowing it is there" and would like to continue to have it. Given she lives alone and has a history of falling, this service continues to be appropriate. Discussed if she was interested in a cordless phone that she could have with her at all times - this would be another method that she could access assistance if need be and she could call 911 on her own. Mrs. Brown said she prefers the PERS because it is "easier to remember to push one*

button.” She also commented that the PERS would be more lightweight than carrying a phone around with her. The HDMs continue to arrive 5 days a week. She said some meals are better than others but she wishes for them to continue, however Mrs. Brown also expressed a desire to have more “homemade” meals. Due to Mrs. Brown’s history of not always having enough energy to make herself a meal at noontime, this continues to be an appropriate service. Discussed the level of care management contacts. Mrs. Brown felt that the current level of monthly telephone calls and home visits every 3 months is sufficient. Re-stated to Mrs. Brown she can call me anytime she has a problem or question. Noted this care manager’s telephone number is still displayed prominently next to her telephone. Discussed the HHA that arrives 2 days a week - Mondays and Thursdays. Mrs. Brown said her aide, Amy McKay, informed her that her last day would be next week as she took a new job. Mrs. Brown hopes her next worker will be just as good and the schedule stays the same. Lastly, Mrs. Brown said she was having trouble getting on/off the toilet. Discussed options - toilet guard rails and/or a raised toilet seat. She would like to try them. Will make arrangements to borrow these items from the loan closet in order for Mrs. Brown to view these pieces of equipment and decide which will be most useful/effective. Mrs. Brown continues to be satisfied with services. Reviewed the outcomes Mrs. Brown identified for herself. They continue to be met on an ongoing basis however we will explore alternative means of meeting her nutritional needs. Mrs. Brown wants to see if the SHC worker can make up some “homemade” meals and freeze them whereby Mrs. Brown would then heat the meals up in the microwave. Care manager will contact SHC Coordinator to discuss request. Next formal review to be conducted in April 2009 during her recertification month.

- 3) The county may develop a form for noting the six-month review has been completed and insert that in the participant’s file.

Sample Questions to pose during a six month review or recertification

REASSESSMENT QUESTIONNAIRE

1. CHOICE AND SELF-DETERMINATION

- Is the consumer happy with his/her providers?”
- What would increase his/her happiness?
- Is the service being delivered consistently, on time, and appropriately?
- Are the providers satisfied that they’re delivering high-quality care?
- Are there difficulties in implementing the plan?
- If so, are those difficulties discussed? Are alternatives being developed that satisfy all parties and can be implemented?

2. ACCESS TO A BROAD RANGE OF STABLE SERVICES AND PROVIDERS WITHIN ONE’S OWN COMMUNITY

- Do providers come when they are supposed to? Is the same individual providing care – a person who knows and is known by the consumer?
- Are services appropriate to the consumer’s needs?
- Do services meet the needs identified by the consumer?
- Are additional services needed? Who says they are needed?
- Are providers expressing concerns about the care plan?
- Are those concerns being addressed with the providers and consumers?

3. PHYSICAL SAFETY AND FREEDOM FROM EXPLOITATION

- Does the consumer report complaints?
- Are providers delivering services?
- If providers refuse to deliver services due to risks, what changes can the consumer make in the care plan?
- Can other providers be found?

4. OPPORTUNITES TO MAINTAIN AND DEVELOP RELATIONSHIPS AND COMMUNITY PARTICIPATION

- Does the consumer see the people he/she wants to see?
- Are the consumer’s expectations about community involvement being met?
- Does the consumer feel fully engaged in community activities if he/she wants to be?
- How does the care plan help the consumer make and sustain the friendships he/she desires?

5. OPPORTUNITIES TO ACHIEVE MAXIMUM SELF-SUFFICIENCY AND INDEPENDENCE

- Is the consumer able to do what he/she wants to do?
- Does the consumer think he/she can do activities that others now do for him/her?
- Are choices available to the consumer?

6. OPPORTUNITIES TO ACHIEVE MAXIMUM HEALTH AND FUNCTIONAL STATUS

- Does the consumer report his/her health and functional status as good?
- Is there any observable danger to the consumer's health and safety?
- Do providers allow the consumer to do as many activities as possible?
- Does the consumer comply with his/her responsibilities as identified in the care plan (e.g., drug regimen, diet)?
- If no, does the consumer understand the risks?
- Does the consumer need assistance in complying with responsibilities?
- Does the consumer's physician, hospital, or others know who the case manager is?

From *Developing Consumer-Centered Quality Assurance Strategies for Home Care – A Final Report*; Riley, Coburn, Fortinsky, and Palmer; Human Services Development Institute; University of Southern Maine; 1989

ISP UPDATES

PURPOSE OF AN ISP UPDATE

The ISP serves as the “living contract” with the participant. It is the only document containing a signature as proof that the individual (or a guardian) agrees with the plan. This agreement is important because it has an effect on estate recovery. The ISP update should be completed in a timely manner so the ISP is up to date and always reflects an accurate picture of the services provided.

PREPARING AN ISP UPDATE

The rules describing when the ISP must be updated and when it must be approved generate many questions. The grid on the following page has been developed to help clarify the rules for different scenarios. The boxes in the top row represent different events. The boxes in the left column represent appropriate responses.

Requirements for Updating the Service Plan

	Waiver-Allowable Service (currently part of plan) is increased or decreased	Waiver-Allowable Service is Added					Institutional Respite	CBRF - 21 and over beds or CBRF (any size) attached to a NH Elderly Only	Waiver-Allowable Service is Deleted from Plan
		Adaptive Aids Communication Aids All Others	Home Modification						
			All ramps	Home mods under \$2,000	Home mods over \$2,000				
Prepare case note	YES	YES	YES	YES	YES	YES	YES	YES	
Add item to ISP and obtain participant's signature	NO ¹	YES	YES	YES	YES	YES	YES	YES	
Prior Approval from TMG required	NO	NO	YES ³	NO ³	YES ³	YES	NO	NO	
Send updated ISP to TMG for approval	NO	NO ²	YES	NO	YES	NO	YES	NO	
Write variance request and send to TMG for approval	NO	NO	NO	NO	NO	YES ⁴	YES	NO	
Written 10-day notice must be sent	Yes - if service is being reduced permanently	N/A	N/A	N/A	N/A	N/A	N/A	YES	

*An example of a case note may be:

10-28-08 PC from Mrs. Jones. She asked if her worker could work additional hours next week as her daughter who usually takes her grocery shopping will be out of town next week & won't be able to do it. Mrs. Jones thought an additional 2 hours would be sufficient. Told her I would call the coordinator of Helpers, Unlimited to authorize the additional hrs for next week.

10-28-08 PC w/ Sue Brown, coordinator at Helpers, Unlimited. Discussed increasing Mrs. Jones SHC next week by 2 to 3 hours. Worker needs to assist w/ grocery shopping. Sue didn't anticipate a problem. Sue said she will call Mrs. Jones directly to arrange the extra hours.

1. Although it is not required, good practice suggests the CM prepare a new ISP & obtain the participant's signature if services are being decreased & an appeal is anticipated. Note: Appeal #6 in the COP Information Bulletin No. 90 (dated 12/16/91) - a participant appealed a reduction of services & won because the ISP did not reflect the reduction.

2. Regarding adaptive aids & communication aids, retroactive to Jan. 1, 1997, it is not required to send an updated ISP to TMG for review. Nor is it necessary to get approval from TMG when purchasing items. Counties should establish their own criteria for purchasing items.

3. Prior approval is required for most home modifications. , All ramps will still need prior approval. For other home modification, only those in excess of \$2,000 require prior approval. A copy of the accepted bid should be sent along w/ the request. Work estimate should have a breakdown of labor and material costs. It is also helpful to include any drawings that may be available to illustrate the project. A template has been developed to aid care managers in getting the correct information from a contractor when the home modification is a wheelchair ramp. See Section 4 of this manual.

4. Information regarding what should be included in a variance request for Institutional Respite can be found in the Medicaid Waivers Manual. A template has been developed to aid care managers in getting this variance request approved. See Section 4 of this manual.

APPENDIX T

PURPOSE OF APPENDIX T

Appendix T details job duties, training requirements, documentation requirements, and prohibitions of supportive home care (SHC) workers, respite care providers, and other individuals authorized to receive payments. For more information, refer to Appendix T. This appendix has been sent to counties by BLTS. See COP Information Bulletin Number 181 dated December 21, 2005.

REQUIREMENTS

The care manager must document that the following requirements have been met:

- **Training**

The table on the following page outlines training requirements.

- **Prohibition of Paid SHC Workers**

- A paid caregiver cannot be the parent of a minor child participant or the spouse of the participant. Note: The waiver can pay the parent of an adult child.

- **Prohibition of Payment**

- Payment for services cannot be made to the participant directly. Note: The check can be made out to the worker and mailed to the participant if the participant is the employer and the county is utilizing a fiscal agent system.

TRAINING REQUIREMENTS

Type of Work Completed	Who Can Do It?	Do They Need Training?	Who Can Do the Training?	When does the Training Have to be Completed?	What Needs to be Documented?
<p>Personal Care (bathing, dressing, transferring, feeding, grooming, ambulation, toileting, etc.)</p>	<p>Private person via fiscal agent funded by the waiver Or Employed with an agency funded by the waiver</p>	<p>Yes. If worker has comparable experience, training is still required in 4 areas:</p> <ul style="list-style-type: none"> • Orientation to County DSS/HSD Policies and Procedures. Also, orientation to contract agency's Policies and Procedures. Participant's rights, confidentiality • Providing services safely • Recognizing and appropriately responding to emergencies • Participant-specific information including individual needs/wants. <p>If worker does not have comparable experience, training is required in the 4 areas listed above and in 3 additional areas:</p> <ul style="list-style-type: none"> • General information regarding target population served • Interpersonal and communication skills/working effectively w/ participants • Homemaking and household services 	<p>The participant, the family, or the agency that hired them.</p> <p>Note: if using a fiscal agency, the county DSS/HSD will have to provide an orientation to Policy and Procedures.</p>	<p>Within 6 months of provider being hired to work with participant or Within 6 months of when waiver funds began paying this provider to work with the participant</p>	<p>That the worker has received training in accordance with Appendix T.</p> <p>That the worker has been oriented to policies/procedures of both the County DSS/HSD, and the contract agency; knows how to provide services safely; understands how to respond to emergencies; and knows the participant's specific needs/wants.</p> <p>In the case of the worker being exempt from the remaining 3 areas, written documentation to indicate he/she already possess the knowledge/skills from previous experience or work experience (perhaps they have already received the training for a Personal Care Worker or Home Health Aide). As a reminder, when a worker is being exempt, documentation still has to be present that indicates the worker has received training in the 4 areas listed in column 3.</p>
<p>Household Tasks only (grocery shopping, laundry, housecleaning, meal preparation)</p>	<p>Private person via fiscal agent funded by the waiver Or Employed with an agency funded by the waiver</p>	<p>Yes. Worker needs training in 4 areas:</p> <ul style="list-style-type: none"> • Orientation to County DSS/HSD Policies and Procedures. Also, orientation to contract agency's Policies and Procedures. Participant's rights, confidentiality. • Providing services safely • Recognizing and appropriately responding to emergencies • Participant-specific information including individual needs/wants. 	<p>The participant, the family, or the agency that hired them.</p> <p>Note: if using a fiscal agency, the county DSS/HSD will have to provide an orientation to Policy and Procedures.</p>	<p>Within 6 months of provider being hired to work with participant or Within 6 months of when waiver funds began paying this provider to work with the participant</p>	<p>That the worker has been oriented to policies/procedures of both the County DSS/HSD, and the contract agency; knows how to provide services safely; understands how to respond to emergencies; and knows the participant's specific needs/wants.</p> <p>There needs to be written documentation to indicate the worker received this training. Should include name of worker and date training occurred.</p>

TRAINING REQUIREMENTS

Type of Work Completed	Who Can Do It?	Do They Need Training?	Who Can Do the Training?	When does the Training Have to be Completed?	What Needs to be Documented?
Lawn Care Snow Removal	Private person via fiscal agent funded by the waiver Or employed with an agency or business.	Yes. Worker needs training in 4 areas: <ul style="list-style-type: none"> • Orientation to County DSS/HSD Policies and Procedures. Also, orientation to contract vendor's Policy and Procedures. Participant's rights, confidentiality • Providing services safely • Recognizing and appropriately responding to emergencies • Participant-specific information including individual needs/wants. 	The participant, the family, or the agency that hired them. Note: if using a fiscal agency, the county DSS/HSD will have to provide an orientation to Policy and Procedures.	Within 6 months of provider being hired to work with participant Or Within 6 months of when waiver funds began paying this provider to work with the participant	That the worker has been oriented to policies/procedures of both the county DSS/HSD, and the vendor agency; knows how to provide services safely; understands how to respond to emergencies; and knows the participant's specific needs/wants. There needs to be written documentation to indicate the worker received this training. Should include name of worker and date training occurred.

NOTES

HUMAN SERVICES REPORTING SYSTEM (HSRS) INFORMATION

PURPOSE OF HSRS

The Human Services Reporting System (HSRS) is used to collect data on social service and mental health participants, the services they receive, and the funds expended for those services. BLTS uses HSRS to provide the federal government with information to substantiate waiver claims, to help local agencies manage their waiver programs, and to develop profiles of waiver participants and services.

ENTERING INFORMATION ON HSRS

County procedures for entering information onto HSRS vary. In some counties, care managers are responsible for data entry; in others, data/fiscal personnel enter the data.

The HSRS Medicaid Waiver Module Form (DSL-467) can be completed to enter waiver information onto HSRS. This includes new cases, updates (changes in services or units billed, changes in care managers, hospital/institutional days, etc.), and case closings. Explanations and options for each field are provided in the HSRS Handbook and the HSRS Long Term Support Module Deskcard. The completed DSL-467 form should be given to the person responsible for keying the information into the system. Please note the following points:

- Medicaid waiver expenditures must be reported on the HSRS Medicaid Waiver Module on a date-of-service basis. *This means that units and costs for services must be reported in the month the services were delivered, not the month the bill was paid.* Reporting should be complete by the last day of the month following the month of service delivery. Please refer to information in the Medicaid Waivers Manual.
- If a waiver participant is in a hospital or institution for less than 30 consecutive days, the HSRS episode should remain open. The institutional days must be reported on HSRS. This can be done by opening a service strip on the HSRS Waiver Module under SPC 503 (inpatient). The service (SPC) start date is the date of admission; the end date is the date of discharge. A new service strip with the appropriate admission and discharge dates must be opened each time the participant enters a hospital or institution, no matter how many times this occurs during an individual waiver episode.
- If a waiver participant is in a hospital or institution for 30 consecutive days or more, the HSRS episode must be closed *as of the date the person was admitted to the institution* (i.e., if an inpatient stay lasting 30 days or more is reported some time after the actual admission date, the closing date of the HSRS episode must be the date of admission, not the date the inpatient stay is reported). Once the participant is discharged and begins to receive waiver services again, a new HSRS episode must be opened. The new episode starting date would be the date of discharge.

- The only services that can be provided during periods of institutionalization are care management (in limited circumstances related to discharge planning done within 30 days of discharge) and Personal Emergency Response Systems (PERS) -- SPC 112.46. Costs for these services incurred while a participant is in a hospital or nursing home should be reported on HSRS as usual if the inpatient stay lasts less than 30 days. If the inpatient stay lasts 30 days or more, there are no open SPCs covering the period of the inpatient stay, so any costs incurred for these services during this period should be aggregated and billed after the new HSRS LTS start date. If no new LTS module is ever developed, aggregate the cost of PERS *only* and add that to the final month of the HSRS module that preceded the institutional admission.

IMPORTANT REMINDER

As mentioned earlier, in the event the participant is in an institution 30 or more consecutive days, the participant's HSRS services (SPCs) must be closed as of the date the participant entered an institution. However, each county must develop their own policy regarding when a participant's case "closes" as it relates to re-serving the participant once he/she is discharged from the institution back to his/her own community residence.

For example: a county may have as its written policy that in the event a waiver participant is in an institution over 6 months, the county considers the waiver participant's case "closed". In the event the waiver participant recovers and wishes to go back to his/her own community residence, the person may find that he/she goes on the county's waiting list for services. Once the person's name comes to the top of the waiting list (and the person has been without waiver services a total of less than a year), in this case, a county only needs to re-open the HSRS LTS module and/or SPCs and begin to serve the participant. A recertification would occur in the original month of the person's waiver start date.

Note: if a person was "off" the waiver program over 12 months, and was going to be served again with waiver funds, it would be considered a new case. A new waiver application would have to be submitted to The Management Group for approval. A new waiver start date would be given.

RECERTIFICATION PROCESS

☞ PURPOSE OF RECERTIFICATION

The Medicaid Waivers Manual requires program participants be recertified annually to ensure that they still meet the level of care and financial eligibility requirements.

☞ PREPARING A RECERTIFICATION PACKET

The care manager is responsible for developing a recertification packet during the recertification month. The recertification packet should include the following items. A recertification workplanning tool is provided in this section.

- **Long Term Care Functional Screen (LTC FS)** - must be completed by a certified screener. The LTC FS must be completed by a certified screener within 12 months from the previous one. The participant must receive a nursing home level of care in order to be found eligible for the COP-W/CIP II program. The level of care must be Skilled Nursing Facility (SNF) – Level I, or Intermediate Care Facility – Level II for continued eligibility.
- **Health Form** - The Health Form must be completed and signed annually by a registered nurse, physician or physician's assistant. The form should be dated within 90 days (before or after) the recertification month. Note: Completion of Part C of the Health Form is optional.
- **Eligibility and Cost Sharing Worksheet (DDE 919) or CWW Screens** - A new worksheet or new CWW Community Waivers Budget page must be completed every 12 months. The care manager may complete the worksheet for Group A participants who are SSI, SSI-E, 1619b, or Katie Beckett. The CWW for some Group A participants and CWW for all Group B and C participants are generated by the Income Maintenance (IM) worker. Note: The IM worker should continue Medicaid certification until a level of care re-determination is made.
- **ISP & ISP Outcomes** - The most recent, updated, and signed ISP should be included in the recertification packet. See Appendix 4 for an example.

☞ **NOTE:** Effective August 1, 2003, counties must complete Group A Recertifications internally. Until notification from the Bureau of Long Term Support, counties retain the option of submitting Group B and C Recertifications to The Management Group, Inc.

☞ **Important reminder:** In the event the COP-W/CIP II participant requires a No Active Treatment (NAT) rating, the participant's NAT must be redetermined at each annual recertification.

☞ COMMON QUESTIONS AND ANSWERS

- **What happens if a waiver participant gets an ineligible level of care at recertification?**

A person who does not receive a nursing home level of care Level I or II on the Wisconsin Long Term Care Functional Screen (LTC FS) will lose waiver eligibility. Because of this, care managers should monitor the situation and work with participants to plan for this possibility. If the care manager feels the person should be eligible, s/he should call a COP-Waiver Quality Assurance Consultant at TMG.

A waiver participant, who loses eligibility because he/she no longer meets the required nursing home level of care, is eligible for COP via Interdivisional Agreement (I. A.) 1.67 if that is the county's current policy. When this happens, COP Level III, Part B of the recertification LTC FS should be completed. Counties establish their own policies about serving these individuals, or where these individuals are placed on the waiting list for COP services.

- **What should be done when a waiver participant is due for annual recertification but the person is in the hospital or nursing home?**

If the participant has been in the hospital or an institution less than one year and recertification was due during institutionalization, the care manager has two options:

- 1) The care manager may case note, in the participant's file, that the participant is in the hospital or institution and that the participant's recertification will be completed immediately upon the participant's discharge. When the participant is discharged, the care manager should send an updated LTC FS, Health Form, updated ISP and new CARES screens for review. If the county completes self-recertifications, as in the case with all Group A's, and perhaps Group B's and Group C's, place the updated information in the file. For those counties that submit Group B and Group C recertification materials to TMG for review, a recertification letter will be sent and there will be no new start date. The original start date will remain in effect.

Or

- 2) The care manager can proceed with the recertification while the participant is in the institution or hospital. Please note the following:
 - Waiver program dollars (with the exception of PERS and some limited care management related to discharge planning) cannot be used when the participant is in an institution. The care manager will need to bill his/her time to COP or administrative funds when completing the paperwork involved in recertifying a participant for the waiver program.

- When completing the recertification ISP, the care manager can either project what services will be needed when the participant is discharged and obtain a signature, or the care manager can send the most recent ISP with the packet and prepare an updated ISP at the time of discharge.
- If the individual is in a nursing home for an entire calendar month, the IM worker will re-determine eligibility for Medicaid using institutional criteria. This will change the medical status code and institute a patient liability, as opposed to any cost share obligation.

Note: For both option #1 and #2, if the participant has been in the hospital or institution for more than a year, a new waiver application must be sent in for review and a new waiver start date will be given.

NOTES
