COVERED SERVICES

This section provides information about the services that are covered in the Adult Day Health Care (ADHC) Waiver program. For the purpose of this policy, whenever reference is made to "individual" or "recipient", this includes that person's responsible representative(s), legal guardian(s) and/or family member(s), as applicable, who are assisting that person in obtaining services.

Support Coordination

Support coordination, also referred to as case management, is a mandatory service designed to assist recipients in gaining access to necessary waiver and other state plan services, as well as medical, social, educational and other services, regardless of the funding source for these services. The core elements of support coordination include the following:

- Intake,
- Assessment
- Plan of Care development and revision,
- Linkage to direct services and other resources,
- Coordination of multiple services among multiple providers,
- Monitoring/follow-up,
- Reassessment,
- Evaluation and re-evaluation of level of care and need for waiver services,
- Ongoing assessment and mitigation of health, behavioral and personal safety risk,
- Responding to recipient crisis,
- Critical incident management, and
- Transition/discharge and closure.

Providers of support coordination shall also be responsible for assessing, addressing and documenting delivery of services, including remediation of difficulties encountered by recipients

in receiving direct services.

Providers of support coordination shall not refuse to serve, or refuse to continue to serve, any individual who chooses/has chosen its agency unless there is documentation to support an inability to meet the individual's health, safety and welfare needs, or all previous efforts to provide services and supports have failed and there is no option but to refuse services. The Office of Aging and Adult Services (OAAS) must be immediately notified of the circumstances surrounding a refusal to provide/continue to provide services. This requirement can only be waived by OAAS.

Providers of support coordination must establish and maintain effective communication and good working relationships with providers of services to recipients served by the agency.

Standards

Providers of ADHC Waiver support coordination must be:

- Certified by the Department of Health and Hospitals (DHH) to operate a support coordination agency,
- Meet the requirements as set forth in the rule for OAAS Home and Community-Based Services Waivers Support Coordination, Standards for Participation,
- Sign a performance agreement with OAAS,
- Assure staff attends all training mandated by OAAS,
- Enroll as a Medicaid provider of support coordination services in all regions in which it intends to provide services,
- Comply with all DHH policies and procedures, and
- Be listed as the provider of choice on the Freedom of Choice (FOC) form.

Reimbursement

Support coordination is reimbursed at an established monthly rate. The data management contractor issues a monthly authorization to the support coordination provider. After the support coordination requirements are met and documented in the Case Management Information System (CMIS), the authorization is released to the support coordination provider. For each quarter in the recipient's Plan of Care/calendar year, if the support coordination provider does not meet all

of the requirements for documentation in the CMIS, the prior authorization (PA) for the last month of that quarter will not be released until all requirements are met. A unit of service is one month.

Transition Intensive Support Coordination

Transition intensive support coordination (TISC) is a service that assists individuals who are currently residing in nursing facilities who want to transition into the community. This service assists individuals in gaining access to needed waiver and Medicaid State Plan services, as well as needed medical, social, educational and other services, regardless of the funding source.

Support coordinators shall comply with all the requirements described above under "Support Coordination." Support coordinators shall initiate and oversee the process for assessment and reassessment, as well as be responsible for ongoing monitoring of the provision of services included in the recipient's approved Plan of Care.

Standards

Providers of ADHC Waiver TISC must be:

- Certified by the DHH to operate a support coordination agency,
- Meet the requirements as set forth in the rule for OAAS Home and Community-Based Services Waivers Support Coordination, Standards for Participation,
- Sign a performance agreement with OAAS,
- Assure staff attends all training mandated by OAAS,
- Enroll as a Medicaid provider of support coordination services in all regions in which it intends to provide services,
- Comply with all Department of Health and Hospitals and OAAS policies and procedures, and
- Be listed as the provider of choice on the Freedom of Choice (FOC) form.

Service Exclusions

Providers of support coordination are not allowed to bill for TISC until after the individual has been approved for the AHDC Waiver.

The scope of TISC shall not overlap with the scope of support coordination; therefore, duplicate billing is not allowed.

Service Limitations

Providers of support coordination may be reimbursed up to six months from the Plan of Care approval date. Reimbursement is contingent upon the support coordinator performing activities necessary to arrange for the individual to live in the community. These activities must be documented by the support coordinator. Providers of support coordination will not receive reimbursement for any month during which no activity was performed and documented in the transition process.

Reimbursement

TISC is reimbursed at a monthly rate as set by Medicaid for a maximum of six months from the Plan of Care approval date prior to the date of transition. Payment will not be authorized until the data management contractor receives an approved Plan of Care indicating that the person was/is a nursing facility resident during the time period in which prior authorization is requested.

Transition Services

Transition Services are time limited, non-recurring set-up expenses for individuals who have been offered and approved for an ADHC Waiver opportunity and are transitioning from a nursing facility to their own living arrangement in a private residence where they are directly responsible for their own living expenses. Allowable expenses are those necessary to enable the individual to establish a basic household. These services must be identified in the individual's approved Plan of Care.

Transition Services include the following:

- Security deposits that are required to obtain a lease on an apartment or house,
- Specific set-up fees or deposits for:
    - Telephone,
    - Electricity,
    - Gas,
    - Water, and
    - Other such necessary housing start-up fees and deposits.

- Essential furnishings to establish basic living arrangements:
    - Living Room – sofa/love seat, chair, coffee table, end table, and recliner,
    - Dining Room – dining table and chairs,
    - Bedroom – bedroom set, mattress/box spring, bed frame, chest of drawers, nightstand, comforter, sheets, pillows, lamp, and telephone,
    - Kitchen – refrigerator; stove, cook top, dishwasher, convection oven, dishes/plates, glassware, cutlery/flatware, microwave, coffee maker, toaster, crock pot, indoor grill, pots/pans, drain board, storage containers, blender, can opener, food processor, mixer, and dishcloths, towels, potholders,
    - Bathroom – towels, hamper, shower curtain, and bath mat,
    - Miscellaneous - window coverings, window blinds, curtain rod, washer, dryer, vacuum cleaner, air conditioner, fan, broom, mop, bucket, iron, and ironing board, and
    - Moving Expenses – moving company and cleaners (prior to move; onetime expense).
- Health and welfare assurances
    - Pest control/eradication,
    - Fire extinguisher,
    - Smoke detector, and
    - First aid supplies/kit.

NOTE: Support coordinators must exhaust all other resources to obtain these items prior to utilizing the waiver.

Standards

Providers of transition services must be:

- Certified by the DHH to operate a support coordination agency,
- Meet the requirements as set forth in the rule for OAAS Home and Community-Based Services Waivers, Support Coordination Standards for Participation,
- Sign a performance agreement with OAAS,
- Assure staff attends all training mandated by OAAS,

- Enroll as a Medicaid provider of support coordination services in all regions in which it intends to provide services,
- Comply with all DHH policies and procedures, and
- Be listed as the provider of choice on the Freedom of Choice (FOC) form.

Service Exclusions

Transition services do not include the following:

- Monthly rent payments,
- Mortgage payments,
- Food,
- Monthly utility charges, and
- Household appliances and/or items intended solely for diversionary/recreational purposes (i.e. television, stereo, computer, etc.).

These services do not constitute room and board. These services may not be used to pay for furnishing or to set-up living arrangements that are owned or leased by a waiver provider.

Service Limitations

There is a $1,500 lifetime maximum limit per individual. Services must be prior approved by the OAAS regional office and require prior authorization (PA).

These services are available to individuals who are transitioning from a nursing facility to their own private residence where the individual is directly responsible for his/her own living expenses. When the individual transitions to a home/apartment that is inhabited with another person, services will only be available for items that are to be used exclusively by the individual.

The purchaser for these items may be the individual, the responsible representative, the direct service provider, the support coordination agency, or any other source. However, the support coordination agency is the only source that can bill for these services.

Reimbursement

Payment shall not be authorized until the OAAS regional office or its designee gives final Plan of Care approval upon receipt of the "Decision Notice" form from the Medicaid office.

When the final approval is issued, the data management contractor is notified to set up a transition service expense record in the database for the individual and to release the authorization. The support coordination provider is notified of the release of the authorization and can bill the Medicaid fiscal intermediary for these expenses. If the support coordination agency did not initially pay for the pre-approved transition expenses, the support coordination agency shall reimburse the actual purchaser within ten calendar days of receipt of reimbursement.

The OAAS regional office or its designee shall maintain documentation, including each individual's "OAAS Transition Services Expense and Planning Approval (TSEPA) Form" with original receipts and copies of cancelled checks, as record of payment to the purchaser(s). This documentation is for accounting and monitoring purposes. (See Appendix B for information about this form)

Billing for transition services must be completed within 60 calendar days after the individual's actual move date in order for the reimbursement to be paid.

NOTE: If the individual is not approved for ADHC Waiver services and/or does not transition, but transition service items were purchased, the OAAS regional office should notify the OAAS state office to allow for possible reimbursement.

If it is determined that additional items are needed after the TSEPA form was approved, and there are remaining TSEPA funds in the individual's budget, the support coordinator must submit a TSEPA form within 90 calendar days after the individual's actual move date. The same procedure outlined above shall be followed for any additional needs.

Adult Day Health Care Service

ADHC services are a planned, diverse daily program of individual services and group activities structured to enhance the recipient's physical functioning and to provide mental stimulation. Services are furnished on a regularly scheduled basis, not to exceed 10 hours a day, 50 hours per week (exclusive of transportation time to and from the ADHC facility), as specified in the recipient's Plan of Care and ADHC individualized service plan (ISP).

An ADHC facility shall, at a minimum, furnish the following services:

- Assistance with activities of daily living (toileting, grooming, eating, ambulation, etc.)
- Health and nutrition counseling,
- Individualized daily exercise program,
- Individualized goal-directed recreation program,
- Daily health education,
- Medical care management,
- One nutritionally-balanced hot meal and two snacks served each day.

  NOTE: A provider may serve breakfast in place of a mid-morning snack.

- Nursing services that include the following individualized health services:

  - Monitoring vital signs appropriate to the diagnosis and medication regimen of each recipient no less frequently than monthly,
  - Administering medications and treatments in accordance with physicians' orders,
  - Monitoring self-administration of medications while the recipient is at the ADHC facility, and
  - Serving as a liaison between the recipient and medical resources including the treating physician.

  NOTE: All nursing services shall be provided in accordance with acceptable professional practice standards.

- Transportation between the recipient's place of residence and the ADHC facility.

  - The cost of this transportation is included in the rate paid to providers of ADHC services. The recipient and his/her family may choose to transport the recipient to the ADHC facility. Transportation provided by the recipient's family is not a reimbursable service, and

- Transportation to and from medical and social activities when the recipient is accompanied by ADHC facility staff.

NOTE: If transportation services that are prescribed in any recipient's approved ISP are not provided by the ADHC facility, the facility's reimbursement rate shall be reduced accordingly. It is allowable for an ADHC to refuse services to someone because the individual resides outside of the ADHC's established limited mileage radius for transportation to and from the center as long as this transportation policy is approved by the DHH Health Standards Section (HSS).

Standards

Providers must be licensed by the HSS as an ADHC provider, enrolled in Medicaid as an ADHC provider and must be listed on the FOC form prior to providing ADHC services.

Service Exclusions

ADHC providers shall not bill for this service until after the individual has been approved for the ADHC Waiver.

ADHC Waiver recipients must attend a minimum of 36 days per calendar quarter, absent extenuating circumstances. The assigned support coordinator, based upon guidance provided by OAAS, must approve exceptions for extenuating circumstances.

It is permissible for a person to attend an ADHC facility outside of their region.

Service Limitations

These services must be provided in the chosen ADHC facility.

Reimbursement for these services requires PA.

Reimbursement

Payment will not be authorized until the OAAS regional office or its designee gives final Plan of Care approval.

OAAS regional office or its designee reviews all documents to ensure all requirements are met. If all requirements are met, the support coordinator provides a copy of the approved Plan of Care to the recipient and ADHC provider. The ADHC provider is notified of the release of the PA and can bill the Medicaid fiscal intermediary for services provided.