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05.10 INTRODUCTION

The philosophy of Community Long Term Care case management in South Carolina is to optimize the participant's life choices and rights, to minimize threats to the participant's safety and health, and to provide a mechanism for managing home and community based alternatives to institutional care. The program allows for a range of options based on choice, role, and responsibility in the decision-making process for persons who want to direct their own home and community based long term care services through the assistance of a case manager, financial management service, and a budget controlled by them for the services identified as needed in their Service Plan.

Community Long Term Care operates on the following program principles which support its case management philosophy:

1. To provide a mechanism for utilizing cost effective alternatives to institutional care and to provide services for those participants eligible within the constraints of affordability by maximizing the utilization of available resources.

2. To ensure services are appropriate to the needs of individual participants, are of acceptable quality, and do not duplicate other formal services.

3. To recognize and strive to honor the participant's decisions regarding locus of care and services received. However, a decision to receive services, including case management cannot be based on race, color, religion, or national origin.

4. To ensure the participant's right to assume risk, commensurate with that person's ability and willingness to assume responsibility for the consequences of that risk.

5. To acknowledge and respect the participant's right to be treated with consideration and dignity.

6. To augment and not replace family members and other informal support systems currently involved with the participant's care.

7. To make service decisions utilizing a multi-disciplinary team approach based on comprehensive, on-going assessments which include input from the participant and the participant's primary caregiver.

8. To provide a well-defined, visible, and accessible point of entry for long-term care services.

Case management is a waivered service that is provided to all participants who

participate in the CLTC program. Case management is a vital part of the long term care service system available to Medicaid eligible participants and ensures continued access to this system.

Some participants may choose and/or need only case management services. In such situations, the value of case management is in the continued follow-up, coordination and monitoring of services other than CLTC waivered services. The **Case Manager** will also be able to periodically evaluate any changes in the participant's service needs.

Case management includes the following five activities which are discussed in this chapter:

- service counseling;
- service planning;
- service coordination;
- monitoring; and,
- re-evaluation.

05.20 Waiver Enrollment

Pre-admission review is completed by a **Nurse Consultant** for a participant who applies for the waiver. Policy and Procedure must be followed for intake, assessment, level of care, and Medicaid eligibility.

A participant must be eligible (has level of care and locus of care, is Medicaid financially eligible, wants to participate in the waiver, and has an available slot) to enter the waiver. If the participant does not enroll in the waiver **within thirty (30) calendar days** of the initial assessment, a new assessment must be completed. It may be necessary to re-verify Medicaid eligibility, depending on the amount of time the case has been pending.

If the initial assessment was completed **within the past 180 calendar days**, a re-evaluation may be completed per phone or visit. A new assessment should be completed in Phoenix and a new level of care determined and recorded in Phoenix.

If the initial assessment is **over 180 days old**, a visit must be made to complete the Assessment. A new level of care determined and recorded in Phoenix.

If the participant appears to be medically ineligible at any time while the case is pending, a visit must be made with the participant to re-determine the level of care.

The **Nurse Consultant** must call to confirm the participant's location and ensure there have been no significant changes in the applicant's condition prior to the transfer conference and enrollment. The **Nurse Consultant** should inform the applicant his/her case is being transferred to the **Case Manager II** for enrollment. The **Nurse Consultant** should notify the applicant that the **Case Manager II** will be calling to discuss service planning and service authorization.

The **Nurse Consultant** and the **Case Manager II** must team staff the assessment information for service plan development and to enter the case into the waiver. The participant's current Medicaid financial category is also reviewed by the **Case Manager II** at the time of the case transfer.

The enrolling **Case Manager II** must complete the following tasks on the date of enrollment which is the same date of the transfer conference:

- Narrate the transfer conference with the Nurse Consultant.
- Change the participant status to "participating" in Phoenix.
- Send a CLTC Notification Form 171 to the participant, primary contact, and/or permitted caregiver supports notifying of the waiver enrollment.
- Notify the designated CLTC Support Staff for RSP indicator entry. The RSP entry must be completed within four (4) calendar days of the waiver enrollment date.

The enrolling **Case Manager II** must complete the following tasks within seven (7) business days of the enrollment date:

- Call participant, primary contact, and/or other permitted caregiver supports to involve in Service Plan development and review the services based on need.
- Contact the participant to confirm or obtain Case Management Provider Choice if the provider choice form has not been received. This contact and the choice of Case Management Provider must be documented in the narrative. This choice must be confirmed at the Initial visit and the provider choice form signed.
  NOTE: If the participant/primary contact does not respond with a Case Management Provider Choice within 5 calendar days, a Notification Form 171 must be mailed to the participant/primary contact informing of the need to make a Case Management Provider Choice within the next 10 calendar days. If the choice is not received within the next 10 calendar days, the Area Administrator must be consulted. The Area Administrator will contact the participant/primary contact to obtain the Case Management Provider Choice. Prior to case closure for this reason, the Area Administrator will discuss with Central Office Designee.
- Key information in Phoenix identifying service plan interventions and updating other sections of Phoenix as needed.
- Team discuss the service plan with State Case Manager, Lead Team, Nurse Consultant or Area Administrator.

- Offer option to make verbal choice of waivered services providers.
  If verbal choice is made, record choice(s) on Provider Choice List in Phoenix, then initial and date form.

  If verbal choice cannot be made, send appropriate Provider Choice List(s) to participant/primary contact. Call participant/primary contact **within seven (7) business days** to secure choice(s) for each planned service. Record choice(s) on Provider Choice List in Phoenix, then initial and date form.

- Explore community services and formal/informal supports.

- Authorize chosen services including Case Management.

- Send Physician's Order if needed, i.e. Nutritional Supplements, Private Duty Nursing.

Once a case is accepted, team staffing must occur with the **Case Manager II** and **on-going Case Manager** within two (2) business days. If the **on-going Case Manager** does not contact the **Case Manager II** within two (2) business days for the team staffing to occur, the **Case Manager II** should proceed to the next Case Management Provider Choice.

05.30 CASE MANAGEMENT POLICIES AND PROCEDURES

05.31 On-going Case Management

The **Case Manager** must make the Initial Visit to the participant **within thirty (30) calendar days** of the waiver enrollment date to complete the following functions:

- Visit participant at his/her place of residence.

- Complete documentation in Care Call by using the participant's home phone for check-in and check-out or by using Authenticare Mobile Phone application. The same phone home care workers use must be used by the **Case Manager.** The **Case Manager's** cell phone may only be used as a last resort with prior approval of **Lead Team Case Manager or Area Administrator.** This prior approval should be documented in the narrative.

- Review Service Plan and change as needed; get Service Plan Agreement signed in Phoenix. Offer a copy of Service Plan to the participant and/or primary contact.

- Review Participant's Rights and Responsibilities Statement; obtain signatures in Phoenix. Make every attempt to have participant and primary contact sign. If participant is unable to sign, see note below. If primary contact is unavailable, mail a copy to primary contact for signature.

- Discuss Choice of Providers Form; obtain choice(s) for each planned service and obtain signature and date.

Note: If participant is not physically or mentally able to complete and/or sign the Choice of Provider(s) Form, the primary contact may do so. The lack of a signature on the form will not preclude the participant from receiving waivered services. The participant may receive waivered services as long as a written choice is indicated on the form.

- Review and update Participant Information, Caregiver Supports, and Home Assessment.

- If the initial assessment was completed by telephone, review assessment and complete all sections if not completed.

- If the initial assessment was completed by telephone, obtain signed Consent Form, DHHS Form 121 in Phoenix.

- If the initial assessment was completed by telephone, obtain signed Service Choice, DHHS Form 164 in Phoenix

- If the initial assessment was completed by telephone for a Category 32 participant, obtain the signed Medicaid Eligibility Statement of Transfer of Assets Form 3400D. The completed and signed form should be forwarded to SCDHHS Central Mail Center, Post Office Box 100101, Columbia, South Carolina 20202-3101.

- If the initial assessment for a Category 16, 32,54, 80, 81,85, or 86 participant who is 55 years or older was completed by telephone, obtain the signed Estate Recovery Notification Form DHHS 1296ER.

- Verify locus choice.

- Review Emergency/Disaster Preparedness status.

- Give CLTC information folder.

- Complete initial visit narrative and related questions in Phoenix.

05.32 Service Counseling

Service counseling involves objectively consulting, discussing, advising, and listening. The CLTC **Case Manager** is in a position to confer with the participant and/or primary contact or other permitted caregiver supports concerning needs and to provide information that will assist them in making sound long term care decisions. The service counseling process includes educating the participant and/or primary contact or other permitted caregiver supports with the long term care options available to them and ensuring the participant's right to be involved in planning his/her care. The various service options and their expected outcomes should be clearly explored with the participant and/or primary contact or other permitted caregiver supports.

Since service counseling is not clinical in nature, it is imperative that the **Case Manager** recognize when a referral for this type of professional intervention is needed. It is essential to assure effective case management so that the **Case Manager** does not become overly involved in complex or emotional situations. The **Case Manager** must be able to distinguish his/her role in service counseling and the need for clinical intervention for the participant and/or primary contact or other permitted caregiver supports. A referral for counseling should be incorporated into the Service Plan when clinical needs are identified.

05.33 Service Planning

Service planning is the active, on-going process of working together with the participant and/or primary contact or other permitted caregiver supports to assure the efficient provision of services. The **Case Manager** should constantly strive to empower the participant to become as independent as possible in advocating for

his/her self and coordinating his/her own care.

In partnership with the team member and other multi-disciplinary team members, the **Case Manager** should work toward developing an agreement with the participant and/or primary contact or other permitted caregiver supports regarding the problems that exist, the goals or outcomes to be reached, and the services and interventions to be explored to reach the goals.

Through service planning the **Case Manager** consistently strives to meet the needs of the participant through the exploration of all informal and formal services.

Coordination with formal and informal services is required for the participant whose needs and/or informal supports are such that an emergency/disaster or the absence of an authorized PCII would have a substantial impact on the participant's health and safety.

Missed PCII Visit Participant At-Risk

A participant at risk for a missed PCII visit is one whose health and safety could be compromised if the service is not provided as scheduled. Some examples are:

- A diabetic participant who resides alone, is unable to prepare a meal, must eat at specific times AND the PCII is responsible for preparing the meal.
- An incontinent participant who relies solely on the PCII to perform bathing and toileting.
- A bed bound participant who relies solely on the PCII to perform activities of daily living and meal preparation.

A participant who is at-risk or becomes at-risk for a missed PCII visit should be identified during the assessment and on-going case management. The At-Risk Status for Missed PCII Visit is keyed in the Participant Information section of Phoenix. This will flag appropriate Service Authorizations to alert providers of the At-Risk for Missed PCII visit status. If the at-risk for missed PCII visit status changes, the Service Authorization must be re-sent to the provider to reflect this change. Service planning must address this special need of the participant.

Emergency/ Disaster Preparedness

The Emergency/Disaster Preparedness information is entered in Phoenix according to the description below. The Emergency/Disaster Preparedness section of Phoenix must be reviewed and updated as necessary, and at least during quarterly and re-evaluation visits. If the participant plans to remain in the home

during an emergency or disaster, the checklist for goods/services which he/she would need should be completed.

Emergency/Disaster Priority

The emergency/disaster priority status is entered into Phoenix according to the description below. Service planning is required in an attempt to meet the needs of a participant who would be vulnerable during an emergency/disaster:

1. Not Priority - Participant is not vulnerable during emergency/disaster or has adequate supports to meet his/her needs. (Example: Participant has functional deficits but family is willing and able to evacuate and/or meet needs.)

2. Priority/Lives Alone - Participant lives alone and is vulnerable in emergency/disaster due to limitation of support system. (Example: Participant lives alone and has no one available to evacuate him/her or has no one to give medications.) If this is chosen, answer the question in Phoenix either yes or no "Participant consents to have emergency preparedness agencies notified."

3. Priority/Advanced Medical Need - Participant has advanced medical needs and would be vulnerable during an emergency/disaster. (Example: Participant is ventilator dependent, requires dialysis or other specialized equipment or services.) If this is chosen, answer the question in Phoenix, either yes or no, "Participant consents to have emergency preparedness agencies notified."

4. Priority/Other - Participant, has special needs as identified by the **Case Manager** and/or **Nurse Consultant**, and would be vulnerable during emergency/disaster. (Example: Participant can only be transported by ambulance or participant with special communication needs.) If this is chosen, answer the question in Phoenix, either yes or no," Participant consents to have emergency preparedness agencies notified."

Service planning includes the development of a written Service Plan in partnership with the participant and parties involved in the Plan. By signing the Service Plan Agreement Sheet at the **Case Manager**'s initial visit (and thereafter at the first quarterly visit following each re-evaluation), the participant, primary contact, and/or other permitted caregiver support, confirms the Service Plan was developed with his/her input and evaluated with him/her at each re-evaluation visit.

The overall goal of service planning is to promote the health and independence of

the participant while involving him/her in all phases of planning, coordination, and evaluation.

05.34 Service Coordination

Service coordination is a vital component of case management and must be documented. The **Case Manager** works together with the participant, primary contact and/or other permitted caregiver supports and other agencies involved in the participant's care to ensure services:

- are appropriate for the participant's needs;
- meet acceptable quality standards;
- are not duplicated;
- are cost effective alternatives;
- maximize the utilization of available resources;
- are provided by other agencies in accordance with maintenance of effort agreements (Refer to Section 07.21); and,
- augment, not replace, the participant's informal support system.

05.35 Monitoring

The **Case Manager** monitors the plan for each waiver participant at least monthly. Monitoring should be accomplished through contacts with the participant and / or primary contact. If the Case Manager is unable to contact the participant and/or primary contact after several attempts on different days/times, approval may be obtained from the Lead Team Case Manager to make the required contact with a knowledgeable other.

The **Case Manager** should contact formal support providers as often as the need arises. Minimally, there should be contact with in-home care providers (excluding providers of incontinence supplies, nutritional supplements, pest control, DME, PERS, HDM, and EM) initially and at the re-evaluation visit. These contacts should be documented in the narrative. Participant's satisfaction with and adequacy of services should be discussed with the participant, primary contact, and/or other permitted caregivers during the initial visit and monthly thereafter. This discussion should be included in the narrative.

All visits and monthly contacts must be conducted between the hours of 7 a.m. and 7 p.m., Monday through Friday.
Note: Any exception must be prior approved by the Area Administrator / Central Office. Any exception should be for the benefit of the participant and not for the convenience of the Case Manager. (**However**, **State Workers must adhere to their approved work schedule.)**

The **Case Manager** must monitor each participant in his/her caseload monthly. At a minimum, the **Case Manager** must contact the participant via phone the first two months of the quarter and visit the participant the last month of the quarter. The **Case Manager** must complete the following monthly contact activities:

- Phone the participant and/or primary contact to discuss the participant's current health-impairment, appropriateness of the Service Plan and provision of formal and informal services at the level committed to. If a change in the health status does not affect the level of care or service plan, document this change in the narrative. If the change affects the service plan but not level of care, document the change in the service plan comments. If the change affects level of care, a re-evaluation must be completed.

- Review Care Call Activity and Exception Reports and follow-up on any problems noted. **No more than 7 calendar days** prior to contact, Care Call Participant Activity Report and the Care Call A2 Exception Report, covering the time period since the last report, must be viewed in Phoenix Claims. **Case Managers and Nurse Consultants** should look for patterns that may indicate problems, not isolated cases. Any problem, subsequent interventions, and resolutions should be narrated.

- Complete Waiver Monthly Narrative.

- Verify Medicaid financial eligibility.

- **Case Manager** must record all Case Management Contact activities in Phoenix immediately after monthly contact is made and documented.

The **Case Manager** must ensure that quarterly visits are completed timely and efficiently. The first quarterly visit is due within 90 days of waiver enrollment and subsequently every 90 days until re-evaluation, which resets the cycle. The **Case Manager** must complete the following quarterly visit activities:

- Visit participant at his/her place of residence. Documentation in Care Call must be completed by using the participant's home phone or by using Authenticare Mobile Phone application. The same phone home care workers use must be used by the **Case Manager**. The **Case**

Manager's cell phone may only be used as a last resort with prior approval of **Lead Team Case Manager or Area Administrator.** The **Case Manager's** cell phone must never be entered into system as an acceptable number for Care Call. The Care Call check-in call should be made at the beginning of the visit AND a check-out call should be made at the end of the visit.

Note:

- If a visit elsewhere, (i.e., ADHC) would benefit the participant and/or primary contact, document the rationale in the Narrative. This number must not be entered in Phoenix as an acceptable number for Care Call.

- In cases where visits are made for more than one person (e.g. married couple in home, visits at a day care center), the **Case Manager** should check in and out for one person at a time, not overlapping the calls to Care Call.

- Update Participant Information and Caregiver Supports in Phoenix as needed.

- Review Assessment and key comments in the pertinent sections as needed.

- Review the Service Plan with the participant and/or primary contact. Make revisions if necessary. Offer copy of revised Service Plan to the participant/primary contact (to be generated and sent to participant). If the service plan is revised, send the revised plan to the appropriate provider(s). This action must be documented in the narrative.

- Obtain signature on Service Plan Agreement Form during first quarterly visit following re-evaluation visit.

- Verify Medicaid financial eligibility.

- Verify locus choice.

- Verify status regarding Emergency/ Disaster Preparedness, Emergency/ Disaster Priority and "At Risk for Missed PCII Visits."

- Review Care Call Activity and Exception Reports and follow-up on any problems noted. **No more than 7 calendar days** prior to contact, Care Call Participant Activity Report and the Care Call A2 Exception Report, covering the time period since the last report, must be viewed in Phoenix Claims. **Case Managers and Nurse Consultants** should look for patterns that may indicate problems, not isolated cases. Any problem, subsequent interventions, and resolutions should be narrated.

- Complete Waiver Quarterly narrative.

- Any problems, subsequent interventions, and resolutions should be narrated.

- During the checkout call to Care Call, enter the activity completed and any new observations. Only new observations that represent a significant change should be entered.

If the participant is hospitalized at the time of the regularly scheduled quarterly visit, the visit should be delayed until the participant is discharged. A visit is due **within seven (7) calendar days** of notification of discharge from the hospital.

Some participants may require more monitoring than others. Frequency of contacts should be determined by prioritizing participants whose medical conditions are unstable, participants who require complex service plans, and/or participants who have limited support systems.

A participant has the right to assume risk, commensurate with his/her ability and willingness to assume responsibility for the consequences of that risk. This, of course, does not abrogate a state's statutory duty to ensure the health and welfare of individuals served under home and community based services waivers. Staff should exercise good professional judgment in dealing with cases where the participant's health, safety, and welfare are questionable. These cases should be staffed with **designated Lead Team** and/or **Area Administrator**. Central Office should also be consulted. Legal counsel may be needed. Established policy (participant choice, monitoring, participant at risk, or non–compliant participant) must be followed. Documentation is crucial in these cases. Referrals must be made to other agencies (DMH, DSS, etc.) as appropriate and/or as required by State Law.

For home environments which have been determined to be unsafe or potentially unsafe for the **Case Manager**, a monitoring strategy should be developed with the **designated Lead Team** based on the CLTC Safety Policy. (Refer to the local CLTC office procedures manual.)

05.35.10 Monitoring for Missed PCII Visit, Emergency/ Disaster Priority and Emergency/Disaster Preparedness

As part of the ongoing case monitoring process, the Case Manager Must identify the participant with special needs and/or inadequate supports. The participant may require special intervention in the event of a missed PCII visit or emergency/disaster.

Missed PCII Visit Participant At-Risk

If a participant is determined by the **Case Manager** to be "at risk for a missed PCII visit," this information must be communicated to the provider at the time of the referral and any time the status changes. The existing authorization should be resent to the provider indicating the changed status. (Refer to Section 05.33 and 07.23)

The provider is required to contact the **Case Manager** if services cannot be provided to the participant as authorized and backup efforts have failed. The **Case Manager** must respond immediately in an attempt to secure the assistance needed by the participant. Efforts to secure assistance must be documented in the Narrative.

At a minimum, interventions will typically include:

- contacting participant and/or primary contact to assess the situation; efforts should be made to involve the participant and/or primary contact in identifying possible solutions;
- reviewing the Service Plan for other informal support systems which could be contacted to assist the participant; and/or
- exploring a change in the PCII provider or authorizing an alternate service on an emergency basis (i.e., ADHC).

Emergency/Disaster Preparedness and Emergency/ Disaster Priority

The emergency/disaster priority status for every waiver participant must be reviewed during the first quarterly visit and at each re-

evaluation.
This status must be recorded in Phoenix with changes made to the status as needed. The **Case Manager** should discuss the "Emergency Preparedness Checklist" and "Emergency Telephone List" with the participant, and/or primary contact or permitted caregiver.

Copies of these forms should be left in the home. The **Case Manager** must request permission from the participant, and/or primary contact or permitted caregiver to share the name of the participant who has been identified as priority for emergencies and/or disasters with the Emergency Management Office, American Red Cross or other emergency agencies. This choice for notification to emergency agencies must be keyed into Phoenix. Service planning must address the special needs of the participant who would be vulnerable during an emergency and/or disaster. The **Case Manager** is responsible for initiating Emergency/Disaster Protocol in the event of an imminent disaster or notification of a participant emergency. (Refer to Disaster Preparedness Manual)

05.36 Assessment Completion at Re-Evaluation

The Assessment is used to re-determine a waiver participant's long term care needs. Information obtained during the re-evaluation process should be adequate for the **Case Manager** to re-determine the participant's level of care, service planning, and service needs.

It is the Case Manager's responsibility to ensure the assessment is completed accurately and thoroughly before a level of care is determined.

05.37 Re-Evaluation at 365-Day Intervals

The **Case Manager** will complete re-evaluations for all waiver participants. A re-evaluation visit with a participant receiving case management is scheduled for completion every 365 days. The 365 day cycle begins with the last assessment completed by the **Nurse Consultant** prior to waiver enrollment. Subsequent re-evaluations will be scheduled 365 days from the date the last assessment was completed. Re-evaluations, levels of care, and service plans must be completed by the due date. Re-evaluations that are due by/on the 7th day of each month may be completed in the month prior to the due date. When the re-evaluation is conducted on a date other than the scheduled date, the 365-day cycle will be adjusted and subsequent re-evaluations will be scheduled 365 days from the date the last assessment was completed.

The **Case Manager** must complete the following re-evaluation activities and upload to network within 365 days:

- Visit participant at his/her place of residence; request input from primary contact and/or permitted caregiver as needed.

Note: If an in- home visit is not realistic, approval must be received from the Lead Team and documented in the Narrative.

- Documentation in Care Call must be completed by using the participant's home phone or by using Authenticare Mobile Phone application. The same phone home care workers use must be used by the **Case Manager**. The **Case Manager's** cell phone may only be used as a last resort with prior approval of **Lead Team Case Manager or Area Administrator**. The **Case Manager's** cell phone number must never be entered in Phoenix as an acceptable number for Care Call. The Care Call check-in call should be made at the beginning of the visit AND a check-out call should be made at the end of the visit.

Note: In cases where visits are made for more than one person (e.g. married couple in home), the **Case Manager** should check in and out for one person at a time, not overlapping the calls to Care Call.

- Verify Medicaid financial eligibility and Medicare eligibility.

- Explore status of private insurance (i.e., COBRA, Tricare). Complete Premium Payment Project Referral Form if appropriate and not previously completed.

- Verify locus of care and health/impairment status.

- Verify status regarding Emergency/ Disaster Priority, Emergency/ Disaster Preparedness and being "At Risk for Missed PCII visits."

- Update all sections of Phoenix and complete a new Assessment and Service Plan.

- Review Service Plan.

- Complete Service Coordination and narrate contacts made.

- LOC must be completed within three (3) business days of the assessment; the service plan must be developed within seven (7)

business days of the assessment; and all re-evaluation activities completed by the 365th day.

Note: Confer with a **Nurse Consultant** if additional input is needed.

- Review Care Call Activity and Exception Reports and follow-up on any problems noted. **No more than 7 calendar days** prior to contact, Care Call Participant Activity Report and the Care Call A2 Exception Report, covering the time period since the last report, must be viewed in Phoenix Claims. **Case Managers and Nurse Consultants** should look for patterns that may indicate problems, not isolated cases. Any problem, subsequent interventions, and resolutions should be narrated.

- Complete Waiver Re-Evaluation Narrative.

- Send any pertinent communication (i.e., Service Authorization/Termination, Service Plan, and Physician's Orders).

- Update Participant Information, Personal Goals, and Caregiver Supports in Phoenix as needed.

- During the check-out call to Care Call, enter the activity completed and any new observations. Only new observations that represent a significant change should be entered.

05.37.10 Re-Evaluation of the Hospitalized Waiver Participant

If a participant is hospitalized at the time of the regularly scheduled re-evaluation, the re-evaluation should be delayed until discharge. Regular case management activities, except a monthly phone contact, must be interrupted during hospitalization. This contact must be documented in the narrative. All other waiver services must be interrupted or terminated according to the professional judgment of the Case Manager.

The re-evaluation is due **within seven (7) business days** of the notification of the participant's discharge from the hospital. At this time, a complete review of the case is required. The re-evaluation must be completed with verification of the participant's locus choice and Medicaid financial eligibility. The 365-day cycle will be adjusted and subsequent re-evaluations will be scheduled 365

days from the date the assessment was completed following discharge.

05.37.20 Re-Evaluation with Interruption of 365-Day Cycle Due to ADL/Medical Changes

It may be necessary, due to reported or observed changes in a participant's condition, to complete a re-evaluation before the re-evaluation is due. This re-evaluation must be completed at the participant's home. A re-evaluation must include a re-determination of the participant's level of care and service needs, verification of locus choice, and verification of Medicaid financial eligibility. Contact must be made with identified agencies and/or providers to ensure service coordination. (Refer to Section 05.34.) A new Service Plan must be developed at each re-evaluation. If the re-evaluation is completed prior to the month that it is due, the next re-evaluation will be due 365 days from the date the re-evaluation was completed.

05.38 Waiver Participant Determined as Medically Ineligible

If a waiver participant appears to be medically ineligible, the **Case Manager** must complete the following tasks:

- Obtain medical information from the physician by mailing or faxing the Physician's Input Letter and the CLTC Consent Form 121.
- Re-visit participant for clarification as necessary which may include a face-to-face visit by a **Nurse Consultant**.
- Conduct a team conference with a **Nurse Consultant** to reach a joint level of care decision. If the assessment was completed by a Nurse Consultant, the team conference will be completed by two Nurse Consultants.
- If a level of care decision cannot be reached, consult with the **Area Administrator**. If the case cannot be resolved in Area Office or if efforts to verify medical information with physician are unsuccessful, the **Area Administrator** will forward the case to Central Office.
- Complete the level of care section in Phoenix.
- Discuss level of care decision and possible alternatives with participant/primary contact.

- Create and mail a 10 day notice of case closure using the CLTC Notification Form 171.

  Note: Participant can continue to receive services through date of case closure.

- Document all activities in the Narrative.

- Terminate all services in Phoenix effective date of case closure.

- E-mail the **designated Support Staff** for RSP closure.

If the participant contacts the **Case Manager** within ten (10) calendar days of the effective date of closure and submits a written request for an appeal, the participant may be eligible to receive continued Medicaid benefits pending a hearing decision. The participant and the provider must be informed that the participant will be required to pay for services received during this period if the hearing decision is not in the participant's favor.

05.38.10 Financial Ineligibility

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

If **Case Manager** receives notification that a waiver participant's financial eligibility is in question, he/she must complete the following tasks:

- Document verification of financial ineligibility via MMIS screen, letter from Social Security Administration, or written notice from Medicaid Eligibility.

- Notify involved agencies by telephone call of participant's termination from CLTC program.

- Contact participant/primary contact to discuss termination, possible alternatives, and referral to other agencies.

- Complete a CLTC Notification Form 171 to notify participant/primary contact indicating the date of termination will be the date of financial ineligibility.

Note: Medicaid Eligibility will be notified via Eligibility Workflow.

- Document all activities in the Narrative.
- Terminate all waivered services in Phoenix effective no later than the same date as financial ineligibility.
- Complete Status Changes section of Phoenix to terminate case as "Financially Ineligible."

A waiver participant who loses financial eligibility for Medicaid for not more than one month due to excess resources, lump sum payment, etc., and is closed to waiver, can immediately be re-entered into the waiver after both financial and medical eligibility have been re-established and verified. A new application must be made with community locus choice and assigned to a **Nurse Consultant**. Normal intake, assessment procedures and timeliness standards will be followed. **Note: If the case is closed for 7 calendar days or less, a problem may be reported in Phoenix to determine if the case may be re-opened without a new application.**

If the participant contacts the **Case Manager** within ten (10) calendar days of the effective date of closure and submits a written request for an appeal, the participant may be eligible to receive continued Medicaid benefits pending a hearing decision. The participant and the provider must be informed that the participant will be required to pay for services received during this period if the hearing decision is not in the participant's favor.

05.39 Institutionalization of a Waiver Participant

If Medicaid sponsorship is required for nursing home placement, the individual must be referred to Centralized Intake for a nursing home placement application. In this scenario, the individual will have more than one application active in Phoenix, one assigned to the Case Manager and one assigned to the Nurse Consultant. The **Case Manager** and **Nurse Consultant** must coordinate the case activities.

Institutionalization of Waiver Participant for Less than a Full Calendar Month

If a waiver participant is hospitalized or institutionalized (i.e., rehabilitation center, nursing home, DDSN/DMH facility) for a planned, temporary stay not to exceed one full calendar month, the waiver application should remain open. (Participant remains in a waiver slot and open in Phoenix.) However, case management activities must be interrupted during the period of hospitalization or institutionalization with the exception of a monthly phone contact by the assigned

Case Manager. This contact regarding the participant's status should be documented in the narrative. All other waivered services must be either interrupted or terminated (Refer to Section 07.26) according to the professional judgment of the **Case Manager**.
If the participant is discharged from the hospital or institution by the end of the last day of the full calendar month, the waiver services may be resumed. Upon discharge the **Case Manager** verifies and documents the participant's status, updates the service plan, and authorizes (or reinstates) services as appropriate. It may be necessary, due to reported changes in the participant's condition to complete a re-evaluation. This can be accomplished by completing the Assessment, re-determining the level of care, and reviewing the service needs. (Refer to Section 05.37 and 05.38.)

Institutionalization of a Waiver Participant for More than a Full Calendar Month

Note: A full calendar month is defined as from the first instant of the month throughout the last instant of the month. For example, if a participant enters a facility before 12:00 a.m. (midnight) on the first day of April and remains throughout the end of April, then waiver closure must occur April 30th. However, if the participant enters a facility after 12:00 a.m. (midnight) on April 1st or on any other day in April, waiver closure must occur on May 31st.

If the participant remains hospitalized or institutionalized for a full calendar month, the waiver application must be closed to the waiver effective no later than the last day of the full calendar month period and the services, which were previously interrupted, must be terminated. This participant must be closed to the waiver as "Exceeded Full Calendar Month" in Phoenix. In order to facilitate waiver re-entry for the participant expected to return to the community, the **Case Manager** will send (at time of waiver termination) a CLTC Notification Form 171 to the participant and/or primary contact and facility discharge planner, requesting that CLTC be notified of participant's impending discharge.

Re-enrollment of Closed Waiver Participant Following the Full Calendar Month Policy

If the closed waiver participant remains eligible for and requires the service, he/she can re-enter the waiver within ten (10) calendar days of discharge date from the institution. Immediately following the closure to the waiver, a Community Choices Waiver Application must be made through Centralized Intake and assigned to a **Nurse Consultant**. Normal intake and assessment procedures and timeliness standards will be followed.

Upon notice that the participant is ready for discharge or has been discharged, the **Nurse Consultant** will complete a new assessment via phone or visit, team staff the level of care with another Nurse Consultant, obtain a signed Consent Form

and Service Choice Form in Phoenix, obtain a signed Case Management Provider Choice Form and verify Medicaid financial eligibility. The case must be transferred to the Case **Manager II** via a team conference and entered into the waiver within ten (10) calendar days of the discharge date. The **Case Manager** II will send the CLTC Notification Form 171 to the participant and/or primary contact. Medicaid Eligibility will be notified of re-enrollment via the Eligibility Workflow.

The on-going **Case Manager** must visit the participant **within thirty (30) calendar days** of the date of enrollment to review and discuss the choice of waiver service(s) provider(s) as well as the service plan. The Participant's Rights and Responsibilities Statement, DHHS Form 119, and Service Plan Agreement Forms are discussed, completed, and signed at this time. The participant does not have to wait thirty (30) days to receive waiver services. The 365-day re-evaluation schedule begins with the last assessment date completed by the **Nurse Consultant** prior to waiver enrollment.

05.39.10 Leave of Absence from the State/CLTC Region of a Waiver Participant

Individuals enrolled in Medicaid home and community-based waivers who travel out-of-state may retain a waiver slot under the following conditions:

1. The trip out-of-state is a planned, temporary stay, not to exceed ninety (90) consecutive days which is authorized prior to departure; and

2. The individual continues to receive a waiver service; and,

3. Waivered services are limited to the frequency of services currently approved in the participant's plan of service; and,

4. Waivered services must be rendered by South Carolina Medicaid providers; and,

5. The individual must remain Medicaid eligible in the State of South Carolina.

If a participant is in another state temporarily, waivered services must be interrupted or terminated, according to the professional judgment of the **Case Manager**, with the exception of case management and possibly PCII or Attendant Care. Documentation of the participant's status and verification of the participant's intent to return should be completed during the monthly phone contact.

If a participant is out-of-CLTC region or out-of-state at the time of a regularly scheduled re-evaluation, the re-evaluation should be delayed until the participant returns. The re-evaluation must be completed **within seven (7) business days** of when CLTC is made aware of the participant's return to the CLTC region or state.
If the participant continues to remain out-of-state after ninety (90) calendar days have elapsed, the individual must be closed to the waiver and all waiver services terminated.

If a participant is in another CLTC region temporarily, the assigned **Case Manager** may negotiate with the involved service provider(s) to coordinate continued services. **Regular case management activities, including (at a minimum) a monthly phone contact by the assigned Case Manager and documentation of the participant's status, should continue**. Verification of the participant's intent to return should also be made during the monthly contact. If the participant remains in another CLTC region for **more than ninety (90) calendar days**, the case will be transferred to that CLTC office or closed to the waiver and all waiver services terminated.

05.39.20 Incarceration of a Waiver Participant

If the **Case Manager** learns that the waiver participant is incarcerated (in jail or prison), all waiver services except case management must be terminated immediately. The participant must be closed to the waiver by or on the last day of the month. No services (including case management) may be billed for in the following month.

05.39.30 Non-Compliant Participant

If a participant and/or primary contact, or permitted caregiver support refuses to cooperate with the CLTC Program, and all alternatives (i.e., counseling, personal contracts, referrals to DSS Adult Protective Services, interagency team staffing, case manager/supervisory visits, etc.) have been exhausted, termination of a waiver service and/or termination from the CLTC Program may be appropriate.

Examples of non-compliance include but are not limited to:

- Repeated refusal to cooperate with providers and/or **Case Manager**;
- Repeated incidences of non-compliance with the service plan;

- Physical abuse or repeated verbal abuse toward provider and/or **Case Manager**; or

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

If **termination of a waivered service for non-compliance** is being considered, the following must occur:

- All efforts to work with the participant/or primary contact must be documented;

- Termination of service must have prior approval of **designated Lead Team** and **Area Administrator**;

- A draft letter must be approved by the CLTC Central Office;

- Participant must be notified of termination of waiver services on the CLTC Notification; and,

- The Service Provision Form terminating service(s) must be sent to the provider(s).

If **termination from the waiver for non-compliance** is being considered, the following must occur:

- The participant and/or primary contact must be notified in writing by certified mail and regular US mail of the program requirements, advised of potential consequences of continued non-compliance and given an opportunity to remedy the circumstances. The letter must have Central Office approval prior to sending to the participant;

- All efforts to work with the participant and/or primary contact must be carefully documented; and,

- Termination must be prior approved by the designated Lead Team member, Area Administrator and CLTC Division Director

05.40 Interactions with Hospice

A participant **can** be in a waiver and the Hospice Benefit at the same time, but is limited in the services that may be authorized. (See Hospice Benefits Interaction Section.) If it is learned that a participant has been receiving services not allowed on the Hospice Benefits Interaction Table, the service(s) must be terminated immediately using the day the information was received as the termination date. For example: Participant admitted to Hospice on 04/15/2014 and on-going Case Manager notified on 04/30/2014 of hospice admission. Participant, primary contact and providers for Personal Care II, Personal Care I, briefs, med pads, and adult wipes are notified of termination. Personal Care II, Personal Care I, briefs, med pads and adult wipes are terminated effective 04/30/2014 to coincide with the date the Case Manager was notified of the hospice admission.

A participant, who has been admitted to a Hospice House, may be open to case management only. All monitoring activities should continue as scheduled, including visits. The waiver application does not need to be closed for "Exceeds Full Calendar Month".

05.50 Process for DSS APS Referrals

If a referral is made to DSS APS by a CLTC Provider Case Manager or Community Long Term Care Staff or if a referral is made to DSS APS by another entity on behalf of a CLTC applicant or participant, the following must occur:

- CLTC **Provider Case Manager/Nurse Consultant** places telephone call to DSS APS Supervisor or County Intake Worker to report abuse, neglect or exploitation regarding a participant.

- Complete Complaint Form in Phoenix after referral is made or after receiving notification that a referral was made on a participant.

- CLTC Notification Letter (Form 171) is sent to APS Supervisor or the APS Case Manager to confirm the referral and to request follow-up regarding status of investigation.

- If APS case is opened, APS services are added to participant's Service Plan. CLTC **Case Manager** will provide information on the service needs/plans with the APS Supervisor or the APS Case Manager.

- **CLTC Provider Case Manager/Nurse Consultant** will monitor progress and collaborate with APS Supervisor or the APS Case Manager monthly and document the status of the APS investigation in the participant's narrative. Monthly follow up is required until APS has closed its case.

- If the **CLTC Provider Case Manager/Nurse Consultant** is unsuccessful in collaborating consistently with the APS Supervisor or the APS Case Manager, he/she will report problem to the Area Administrator or to the Lead Team who will contact the APS Supervisor or the APS Case Manager. If this is not successful, the **Area Administrator or Lead Team** should contact the Regional APS Consultant and is this is not successful, the **Area Administrator or Lead Team** should contact Central Office Quality Assurance Coordinators for assistance.

- If a participant moves to another county and there is an open APS case or a referral has been made on a participant, **the CLTC Provider Case Manager/Nurse Consultant** should notify the APS worker of the participant's move.

- The **CLTC Provider Case Manager/Nurse Consultant** should follow CLTC policies and procedures related to case transfer.