SPPC/AIDS WAIVER MANUAL

Developed by the Missouri Department of Health and Senior Services,
Bureau of HIV, STD, and Hepatitis

MO HealthNet State Plan Personal Care (SPPC) and AIDS Waiver Manual Table of Contents

MO HEALTHNET STATE PLAN PERSONAL CARE (SPPC) AND AIDS WAIVER SERVICES

Purpose

The MO HealthNet AIDS Home and Community-Based Waiver is designed to allow clients who have HIV or AIDS, are MO HealthNet eligible and have intense medical needs, to receive care in their homes as a cost-effective alternative to placement in a nursing facility. The Department of Social Services, MO HealthNet Division, administers the AIDS Waiver along with all other MO HealthNet benefits. The Department of Social Services has an inter-agency agreement with the Department of Health and Senior Services to assess clients for waiver services and authorize care through the Department of Health and Senior Services Missouri Ryan White HIV Medical Case Management system.

Missouri is the recipient of this Waiver under section 1915(c) of the Social Security Act. This waiver permits state MO HealthNet agencies to cover services that are of benefit to clients that exceed program limitations, are not included in the standard MO HealthNet benefit package or state plan, and will result in cost savings to the state. The MO HealthNet AIDS Home and Community-Based Waiver allows eligible clients to receive the following in-home services to meet their medical needs:

- State Plan Personal Care (SPPC)
- Waiver Personal Care (WPC)
- Advanced Personal Care (APC)
- HIV/AIDS specific supplies (adult incontinence briefs, underpads, gloves)
- Attendant Care
- Private Duty Nursing (PDN)
- Authorized Nurse Visit

MO HEALTHNET State Plan Personal Care/AIDS WAIVER GUIDELINES

The total State Plan Personal Care/AIDS Waiver service coverage in any combination is limited to an average of sixteen (16) hours daily. A combination of basic personal care, advanced personal care, and waiver personal care may not exceed an average of sixteen (16) hours daily. If a client requires more than sixteen (16) hours of care per day, the client will not be eligible for SPPC/Waiver services unless the client and/or family, with the assistance of the case manager, can arrange for an additional eight (8) hours of care through an alternate payer source. If that is not possible, the client and/or family, with the assistance of the case manager, must arrange for an alternative location where twenty-four (24) hour nursing care is provided. Attendant Care Services authorized under the AIDS Waiver are not subject to the sixteen (16) hour daily limit.

This policy will allow for short-term twenty-four (24) hour per day coverage. However, whatever combination is used, services must not exceed the monthly average of 480 hours of care in a 30-day month or 496 hours of care in a 31-day month. The Authorized Licensed Nurse or Supervisory RN visits are not counted in the monthly total.

Requests to exceed the stated limitations should be rarely used. Requests to exceed the stated limitations should be directed to the Section for Disease Prevention, Bureau of HIV, STD, and Hepatitis, Regional Quality Service Manager. When making this type of request, the Service Authorization and any other pertinent documentation should be provided to the Regional Quality Service Manager. The exception request should contain the exact extent of services exceeding the stated limitation and clear justification for the needed services. Authorizations will be granted based on the client's short-term needs and available waiver dollars.

Basic Personal Care/Waiver Personal Care/Advanced Personal Care

As of July 1, each year, the maximum number of units per month allowed for Personal Care changes. Basic Personal Care (BPC), Waiver Personal Care (WPC), and Advanced Personal Care (APC) may be used in combination, not to exceed an average of sixteen (16) hours daily. When authorizing APC, at least one nurse visit must be authorized per month. Additional nurse visits are authorized based on the client assessment and professional judgment of the case manager in collaboration with the provider. When APC has authorized the combination of BPC, APC, and Nurse Visits may go up to, but cannot exceed the yearly cost cap for the fiscal year that is set annually by the MO HealthNet Division.

Authorized Nurse Visit

Clients receiving Authorized Nurse Visits must also be receiving Personal Care Visits. A maximum of 26 Authorized Nurse Visits may be authorized for each six month period (maximum of 52 visits per year).

Waiver Supplies – Durable Medical Equipment (DME)

- Adult incontinence briefs
- Gloves
- Underpads

Attendant Care Services

- Limited to 1 unit per day (1 unit equals one day)
- Initial authorization requires approval by Quality Service Manager (QSM)
- A client must reside in an approved residence
- Must be available to individuals 24 hours a day
- Individuals receiving Attendant Care Services are not eligible for any other SPPC/AIDS Waiver services with the exception of Supplies.

Private Duty Nursing

Private Duty Nursing (PDN) is the delivery of skilled nursing services (provided by an RN or LPN) within the home. Services include assessing HIV-related illnesses which may require medical intervention, reporting changes in the client's condition to the physician, providing IV therapy, providing respiratory care including oxygen, changing dressings and caring for wounds, making referrals, and teaching family members and others about the necessary care to maintain the client at home.

Procedure Codes

SPPC/Waiver	Procedure Code	Service
SPPC	T1019	Basic Personal Care (BPC)
SPPC	T1019 TF	Advanced Personal Care (APC)
SPPC	T1001	SPPC -Nurse visit
AIDS Waiver	T1019 U4	Waiver Personal Care (WPC)
AIDS Waiver	T1000 U4	Private Duty Nursing (PDN)
AIDS Waiver	T2028 U4 NU	Supplies (delivered by DME)
AIDS Waiver	S5126 U4	Attendant Care Services

Revisions (Changes in Authorized Services)
If changes in services are indicated by the case manager's ongoing evaluation and assessment, the Service Authorization must be revised and approved by the QSM. A copy of the revised Service Authorization must be scanned into SCOUT and notification, by way of a Communicate in SCOUT, and emailed to the SPPC/AIDS Waiver Liaison. Revisions are needed for the following situations:

- Increasing or decreasing the number of units of services
- Adding new services
- Discontinuing services
- Changing providers

Revisions to the original Authorization Determination Letter will be made and sent to MO HealthNet to be changed in the MO HealthNet database. A new Authorization Determination letter will then be issued and distributed to providers as usual. A copy is scanned into SCOUT.

Coordination with Other Programs:

Clients Receiving Services from Hospice

- Clients enrolled in Hospice and receiving SPPC/AIDS Waiver services are subject to the same limitations as other SPPC/AIDS Waiver clients.
- There is to be no duplication of services between Hospice and AIDS Waiver care. The Hospice Program is responsible for all supplies related to the terminal illness.

Clients Enrolled in MO HealthNet Managed Care (formerly MC+)

- HIV/AIDS diagnosed clients under the age of 21 must receive their care through their MO HealthNet Managed Care Health Plan.
- Individuals who have qualified for waiver must be disenrolled from their MO HealthNet Managed Care health plan and become MO HealthNet fee for service clients (MO HealthNet Aged, Blind, and Disabled- ME codes 11, 13, or 16).

Clients under the age of 21

- Clients not residing in an area covered by a MO HealthNet Managed Care plan may receive their care from the Healthy Children and Youth (HCY) program. Requests for HCY Services should be directed to the Department of Health and Senior Services, Bureau of Special Health Care Needs.
- Primary service coordination for clients under 21, who are not enrolled with a MO HealthNet Managed Care plan, will be provided through the Department of Health and Senior Services, Bureau of Special Health Care Needs.

MO HealthNet Eligibility (ME) codes eligible for SPPC/AIDS Waiver

To qualify for SPPC/AIDS Waiver services, MO HealthNet participants must have one of the following active ME codes:

- Code 11 (MO HealthNet Old Age Assistance)
- Code 13 (MO HealthNet Permanently and Totally Disabled)
- Code 16 (MO HealthNet Nursing Care Assisted Living Facility)

MO HealthNet Eligibility (ME) codes ineligible for SPPC/AIDS Waiver

ME codes that disqualify participation for the AIDS Waiver program are listed in the following chart. Note: if a MO HealthNet participant has one of the following codes in addition to a code 11, 13, or 16, he/she may still be eligible for SPPC/AIDS Waiver services. Contact the SPPC/AIDS Waiver Liaison for confirmation of eligibility.

MO HealthNet Eligibility (ME) CODES- Not eligible for AIDS Waiver Programs Table 1.2-1

ME Code	Program Type
02	Individuals who receive a Blind Pension check
08	Children and youth under age 21 in DSS Children's Division foster homes or who are receiving state-funded foster care
09	General Relief*
52	Children who are in the custody of the Division of Youth Services (DYSGR)
55	Individuals who do not qualify for a public assistance program but who meet the Qualified Medicare Beneficiary (QMB) eligibility criteria
57	Children who receive a state only adoption subsidy payment
59	Pregnant women who received benefits under the Presumptive Eligibility (TEMP) Program but did not qualify for regular Medicaid or MC+ benefits after the formal determination.
64	Children who are in the custody of Juvenile Court who do not qualify for federally matched Medicaid under ME codes 30, 69, or 70.
65	Children placed in residential care by their parents, if eligible for MC+/Medicaid on the date of placement

* General relief participants and uninsured working parents are not eligible for State Plan Personal Care

STATE PLAN PERSONAL CARE (SPPC) SERVICES

State Plan Personal Care (SPPC) includes:

- Basic Personal Care (BPC)
- Advanced Personal Care (APC)
- Authorized Licensed Nurse Visit

MO HealthNet participants with Medicaid Eligibility (ME) codes of 11, 13, or 16 are eligible for SPPC. Participants in medical eligibility category 09 (general relief), 76, 77, 78, 79 or 80 are not eligible for SPPC.

Basic Personal Care (BPC)

Basic Personal Care is a program designed to maintain a client in his/her home by assisting the client with activities of daily living and assisting with medically related household tasks (minimal household chores and energy conservation activities). BPC services provide assistance with activities of daily living such as bathing, grooming, dressing, house cleaning, laundry, and meal preparation in the client's home. Basic Personal Care services are performed by qualified individuals and supervised by a licensed nurse. Personal care services must be provided by a qualified individual who is not a member of the participant's family or household. NOTE: A family member is defined as a parent, sibling, child by blood, adoption, or marriage, spouse, grandparent, or grandchild. MO HealthNet will not reimburse family members to provide care. Basic Personal Care services are provided by an agency with a valid MO HealthNet Personal Care Provider Agreement in effect with the MO HealthNet Division.

Advanced Personal Care (APC)

Advanced Personal Care includes maintenance services provided to assist a client with a stable, chronic condition with activities of daily living when such assistance requires devices and procedures related to altered body functions.

Examples of Advanced Personal Care services, which may be performed, are:

- Routine personal care for persons with ostomies (including tracheostomies, gastrostomies and colostomies with a well-healed stoma) and external, indwelling, and suprapubic catheters which include changing bags and soap and water hygiene around ostomy or catheter site
- Remove external catheters, inspect skin, and re-application of same
- Administer prescribed bowel program including use of suppositories and sphincter stimulation, and enemas (pre-packaged only) to clients without contraindicating rectal or intestinal conditions
- Apply medicated (prescription) lotions or ointments, and dry, non-sterile dressings to unbroken skin

- Use manual or electric lift for transfers
- Assist with oral medications which are set up by an RN or LPN
- Provide a passive range of motion (non-resistive bending of joint delivered in accordance with the Plan of Care, unless contraindicated by underlying joint cause)
- Apply non-sterile dressings to superficial skin breaks or abrasions as directed by an RN or LPN
- Advanced Personal Care should never be used as a therapeutic treatment, i.e., active range of motion

All Advanced Personal Care clients must have at least one authorized licensed nurse visit per month.

Advanced Personal Care is provided by any agency with a valid MO HealthNet Personal Care Provider Agreement in effect with the MO HealthNet Division and a signed addendum to their Personal Care Provider Agreement. Personal care services must be provided by a qualified individual who is not a member of the participant's family or household. NOTE: A family member is defined as a parent, sibling, child by blood, adoption, or marriage, spouse, grandparent, or grandchild.

Authorized Licensed Nurse Visit
The Authorized Licensed Nurse visit is a covered service under the MO HealthNet Personal Care Program. Authorized Licensed Nurse services are provided by an agency with a valid MO HealthNet Personal Care Provider Agreement in effect with the MO HealthNet Division. A Registered Nurse (RN) or a Licensed Practical Nurse (LPN) under the direction of an RN may provide the Authorized Licensed Nurse visit.

To be eligible for the Authorized Licensed Nurse Visit, the client must meet an institutional level of care requirements based on the HIV Level of Care Assessment (HIVLOC) tool. The total points must be assessed at 18 or greater (equal or greater to the current State of Missouri Nursing Home Level of Care). The client cannot receive only nurse visits. The client must be receiving at least one other SPPC service. Up to twenty-six (26) Authorized Licensed Nurse visits may be used within a six (6) month period.

All Advanced Personal Care clients must have at least one Authorized Licensed Nurse visit per month.

The purpose of the Licensed Nurse visits is primarily to provide increased supervision to the personal care aide, assessment of the client's health, and the suitability of the Plan of Care in meeting the client's needs.

This service may be authorized for one or more of the following:

- When the personal care aide requires increased supervision
- To conduct general health evaluations of the client
- Setting up oral medications
- Monitoring the client's skin condition when the client is at risk of skin breakdown

MO HEALTHNET AIDS WAIVER PROGRAM SERVICES

The Missouri Medicaid AIDS Home and Community-Based Waiver is designed for persons living with HIV that, due to their disease, have a decreased level of function. The Waiver allows qualified HIV positive, Medicaid eligible clients to receive care in their homes as a cost-effective alternative to placement in a nursing facility. The main goal of the Waiver is to encourage the client to reach an optimal level of function through services within the community. The Department of Social Services, MO HealthNet Division, administers the AIDS Waiver along with all other Medicaid benefits. The Department of Social Services (DSS) has an inter-agency agreement with the Department of Health and Senior Services (DHSS) to assess clients for waiver services.

The State of Missouri is the recipient of the Medicaid AIDS Home and Community-Based Waiver under section 1915(c) of the Social Security Act. This Waiver permits state Medicaid agencies to cover services that exceed program limitations or that are not included in the standard Medicaid benefit package or state plan. The Waiver allows eligible clients to receive the following services:

- Waiver Personal Care
- Supplies
- Attendant Care
- Private Duty Nursing

To receive AIDS Waiver Program services, a client must be HIV positive, enrolled in HIV Medical Case Management, be MO HealthNet eligible (ME code 11, 13 or 16), and meet institutional Level of Care (LOC) requirements. An individual must also meet at least two (2) of the following medical criteria:

- Multi-organ failure (ex. liver, kidney, heart, pancreas, lung)
- Support to maintain vital functions and/or maintain complex IV therapy, peripheral nutrition, central venous catheters, daily diabetic blood sugar tests, and insulin injection
- Assessment and assistance with pain control and/or pain therapy during acute and terminal phases of illness
- Oversight as related to dementia and/or severe chronic and persistent mental illness (ex. Bipolar, multiple suicide attempts, schizophrenia, and confusion)
- Oversight related to a terminal phase of an illness
- Licensed nursing care on a regular basis to assist in recovering from opportunistic infections and/or acute illnesses
- Weekly monitoring required by a licensed nurse and/or physician to provide an assessment for opportunistic infection (signs and symptoms)
- Licensed nursing care on a regular basis to assist with medication set up, adherence and monitoring for serious side effects

- Monitoring and assistance to maintain safety/optimum mobility related to neurological deficits (ex. Neurophy or uncontrolled seizures)
- Oversight as a result of co-morbid complications (ex. Substance abuse, secondary disease processes, TB and hepatitis)

Individuals in need of Waiver Personal Care and/or supplies who do not meet two of the above medical criteria must be approved by the Quality Service Manager (QSM) prior to authorization of Waiver Personal Care and/or supplies. If the QSM gives approval, case managers must receive written approval and document in the client chart.

Waiver Personal Care (WPC) Services

Waiver Personal Care services is an extension of the basic personal care services that are provided through the State Plan Personal Care program. Therefore, Waiver Personal Care is defined the same as Basic State Plan Personal Care, with the distinction that WPC is the personal care that is authorized when the client requires personal care services in excess of the allowed number of hours (4 units = 1 hour) available through the SPPC program. Personal Care provides assistance with activities of daily living such as bathing, grooming, dressing, house cleaning, laundry, and meal preparation in the client's home. Personal Care Services are provided by qualified individuals who are supervised by a licensed nurse. Personal Care services *must* be provided by a qualified individual who is *not* a member of the participant's family or household. NOTE: A family member is defined as a parent, sibling, child by blood, adoption, or marriage, spouse, grandparent, or grandchild.

Waiver Personal Care is authorized only after SPPC hours/amounts have been fully utilized. Waiver, Personal Care providers, may accompany clients for non-emergency medical care or may read and write essential correspondence. Waiver, Personal Care providers, must meet the same qualifications as SPPC providers.

Supplies

The only supplies provided under the AIDS Waiver Program are underpads, adult incontinence briefs, and gloves. Supplies will be authorized as units with the actual cost on the Service Authorization and Prior Authorization. Clients do not need to be receiving personal or skilled services to receive supplies but must meet AIDS Waiver Program eligibility criteria.

The case manager will determine the actual cost of the supplies to be authorized through contact with the client's chosen provider. Durable medical equipment providers (provider type 62) may furnish adult incontinence briefs, underpads, and gloves to AIDS Waiver Program participants.

Attendant Care Services

Attendant Care Services are furnished to waiver participants living with HIV who have co-occurring health conditions and/or challenges meeting their basic needs who reside in a homelike, non-institutional setting. This setting must include 24-hour on-site response capability to meet scheduled or unpredictable resident needs and to provide supervision, safety, and security. Services also include social and recreational opportunities and medication assistance (to the extent permitted under State law). Additional services provided within the Attendant Care Service category include but are not limited to the following: crisis intervention/management, personal assistance, medical transportation coordination, enteral nutrition, support, and referral for therapeutic management of substance abuse and psychiatric issues, meal planning and preparation, dietary assessment and education, cooking classes, medical supplies and ordering, medical and psychiatric care planning, medication adherence education and coordination, medical care coordination and physician follow-up, monitoring of vitals, minimal wound care, injectable medication assistance, IVs, lab draws, grooming/dressing assistance, meal assistance and observation, and rehabilitative services (PT, OT, alternative therapies). The goal of this service is to help individuals reach an optimal level of function and to return to a less restrictive environment within the community. The Attendant Care Service category does not include payment for room and board. A unit of service is defined as one calendar day.

Private Duty Nursing (PDN)

Private Duty Nursing (PDN) is the delivery of skilled nursing services (provided by an RN or LPN) within the home. Services include assessing HIV-related illnesses which may require medical intervention, reporting changes in the client's condition to the physician, providing IV therapy, providing respiratory care including oxygen, changing dressings and caring for wounds, making referrals, and teaching family members and others about the necessary care to maintain the client at home.

ELIGIBILITY

To receive State Plan Personal Care or AIDS Waiver Program Services, clients must be Medicaid eligible and meet an institutional level of care. Additionally, clients must be HIV positive and engaged in the MO Ryan White HIV Medical Case Management system. The criteria for authorization of MO HealthNet State Plan Personal Care and AIDS Waiver Services using the *HIV Level of Care (HIVLOC) Assessment* is as follows:

HIVLOC Assessment

SPPC HIVLOC requirements	**AIDS Waiver HIVLOC requirements**
HIVLOC ≥ 18	HIVLOC ≥ 18 *and* Two (2) or more Medical Criteria or QSM approval

MO HealthNet

- All MO HealthNet eligible clients will have verification stating their eligibility dates for MO HealthNet before services begin. Verification of eligibility must be documented in the chart.
- Each client requesting State Plan Personal Care or AIDS Waiver Program services must apply to the Family Support Division if they are not currently MO HealthNet eligible. **(A client must be MO HealthNet eligible each day that services are provided.)**

AIDS Waiver- MO HealthNet Active

- Clients must be eligible for Medical Assistance in order to receive SPPC or AIDS Waiver services.
- Providers will be advised that services should not be initiated until they have received written confirmation from the case manager **or** SPPC/AIDS Waiver Liaison in the Bureau of HIV, STD, and Hepatitis.
- MO HealthNet Waiver eligibility is assessed during each contact or home visit**.** If there is any question about the MO HealthNet AIDS Waiver eligibility of a client for State Plan Personal Care or AIDS Waiver Program services, the case manager must contact the SPPC/AIDS Waiver Liaison in the Bureau of HIV, STD, and Hepatitis.

Spenddown

- Spenddown Assistance will be paid in full directly to MO HealthNet on behalf of eligible clients each month.

- DHSS routinely matches HIV case management enrollment with MO HealthNet enrollment to identify and prepay non-dual or SPPC/Waiver client's monthly spenddown. The data matching process occurs 45 days prior to the month of payment.

- The HIV medical case manager may request an individual spenddown payment under certain circumstances. The following outlines the process for these requests.

  New SPPC-Waiver client who needs their spenddown paid:
  The client must supply written verification of the spenddown amount to the case manager. The document should be scanned into SCOUT. The case manager should then send a Communicate through SCOUT to the BHSH ADAP and Rebate Liaison and the Senior Program Specialist with Healthcare Strategic Initiatives (HSI). This communicate will allow the client to be put on future Spenddown lists as well as to ensure that any current Spenddown gets paid.

Qualified Medicare Beneficiary (QMB)

- Clients may have Qualified Medicare Beneficiary (QMB) plus MO HealthNet, or they may have QMB only.
- Clients that have QMB ***only*** <u>are not eligible</u> for SPPC/AIDS Waiver services. (ME code ***55***.)
- Clients that have QMB ***and*** MO HealthNet (ME codes 11, or 13) **are eligible** for SPPC/AIDS Waiver services as long as they maintain an active ME 11, or ME 13 status.

Specified Low-Income Medicare Beneficiary (SLMB)

- Clients may have Specified Low Income Medicare Beneficiary (SLMB1) – The participant is Medicaid eligible based <u>on meeting spenddown</u>. When the Spenddown is not met then the participant is not Medicaid Eligible, but still SLMB eligible (meaning part B premium will be paid). The participant has Medicaid benefits + part B premium paid when spenddown is met.
- Clients may have Specified Low Income Medicare Beneficiary (SLMB2) - does not qualify for Medicaid, just payment of Medicare part B premium. **Not eligible for SPPC/Waiver.**

Other MO HealthNet Eligibility Categories

- A client receiving Blind Pension (ME code 02) is eligible for MO HealthNet benefits, including State Plan Personal Care services. They **<u>are not eligible</u>** for AIDS Waiver services. <u>Blind Pension participants do not have to meet spend down regardless of their income.</u>
- Clients who are on <u>state-only ME codes are not eligible for the AIDS Waiver</u> program.

SPPC/WAIVER FORMS

HIV Level of Care (HIVLOC)

The HIV Level of Care (HIVLOC) assessment is used to determine the Level of Care.

- To be eligible for State Plan Personal Care/AIDS Waiver services, an individual must require care at an institutional level. The total points must be assessed at 18 or greater (equal or greater to the current State of Missouri Nursing Home Level of Care) on the assessment.
- To be eligible for AIDS Waiver services, an individual must require care at an institutional level. The total points must be assessed at 18 or greater (equal or greater to the current State of Missouri Nursing Home Level of Care), and it must include a minimum of two (2) medical criteria.

For both State Plan Personal Care and AIDS Waiver Services, the HIVLOC must be completed a minimum of once annually or with any changes. However, it is recommended that the HIVLOC be completed every six months, or with any changes due to the unstable nature of HIV disease as well as the overall goal of encouraging the client to reach his/her optimal level of function and mobility. (Additional information and form completion instructions can be obtained in Subsection 2.1)

Personal Goals Section and Emergency Plan

The Department of Health and Senior Services has developed an emergency plan form to assist the client with preparing for an emergency by providing a convenient tool to document all necessary emergency information on one form. (Additional information and form completion instructions can be obtained in Subsection 2.10)

HIV/AIDS Client Choice Statement

The purpose of the HIV/AIDS Client Choice Statement is to ensure that the client has been given a choice between SPPC/AIDS Waiver services or nursing home care; choice of who participates in Service Authorization development, choice of provider agency and the right to receive services in settings that are integrated and support full access to the greater community. The HIV/AIDS Client Choice Statement must be completed before services can be authorized. A new form must be completed every six (6) months or with any new update and re-admission. A new form must be completed when a client is readmitted to State Plan Personal Care or AIDS Waiver services for any reason other than a break in eligibility. (Additional information and form completion instructions can be obtained in Subsection 2.2)

Service Activity Instructions
The purpose of the Service Activity Instruction is to inform the personal care agency of the approved services they are to provide to the client. The case manager should check any and all services for which the client requires assistance from the provider agency. All clients requiring assistance with Medically Related Household tasks shall have at least one Personal Care task selected. The Case Manager will check only tasks that the client requires assistance in completing. The Case Manager will then fax the Service Activity Instructions to the provider for signature with a request to return within ten (10) days. (Additional information and form completion instructions can be obtained in Subsection 2.3)

Service Authorization
The purpose of the Service Authorization is to provide information to DHSS, allowing them to file a prior authorization request for services with MO HealthNet. When approved, an Authorization Determination Letter is returned to DHSS, copied and provided to the case manager and provider agency.

The Service Authorization is developed by the client (the client may request the participation of family members or other designated parties) and the case manager when services are agreed upon, and the client has made a provider choice. Service authorizations for SPPC/AIDS Waiver program may be developed for one to six months. The Service Authorization lists all services and the number of units of service authorized. The Service Authorization must include the dollar amount of the services authorized under the AIDS Waiver Program. Basic Personal Care used in combination with Advanced Personal Care, must have at least one Authorized Nurse visit per month.

Authorization Determination Letter
Authorization Determination Letter advises the case manager and agency of the maximum number of units of service that a provider may bill for after services have been delivered. It is not a guarantee of payment for billed services.

Supervisory Monitoring Log
The purpose of the Supervisory Monitoring Log is to provide follow up information to the case manager regarding services rendered by the provider agency. If all authorized units of care are not delivered, a reconciliation is completed, reflecting the non-delivery of care allows funds to be reallocated and fully utilized to serve other clients. It also provides documentation to the case manager and Quality Service Manager when a provider has not met their obligations. The Supervisory Monitoring Log must be completed for any non-delivered services and must be returned to the Case Manager by the 10th of the following month.

Notification of Change

The purpose of the Notification of Change Letter is to notify a client of their change in service status. A Notification of Change Letter will be mailed to the client if the client's State Plan Personal Care or AIDS Waiver Program services are reduced, terminated, or denied for any reason other than death or MO HealthNet eligibility interruption under MO HealthNet's Spenddown eligibility program. Please ensure that the Notification of Change Letter is on agency letterhead. In circumstances in which services are reduced or terminated, the client must be notified by mail at least ten business (10) days before the date of the action.

Provider Notification of Client Letter

The Provider Notification of Client letter may be used to officially notify a provider agency when a new client has been referred for services. This letter also outlines the required documentation for participation in the SPPC/AIDS Waiver program. This form is optional.

Case Management Authorization for Personal Client Medical/Health Information (PHI)

The purpose of the Case Management Authorization for Personal Client Medical/Health Information (PHI) form is to provide the case manager with the permission of the client to request copies of medical records from other service providers, clinics, hospitals, and physicians. These records will expand the knowledge of the case manager in order to more effectively assess and plan for the client's needs. A PHI should be completed in order to discuss client information with the provider agency.

Monitoring Service Delivery

Supervisory Monitoring Log

The Supervisory Monitoring Log is used to facilitate communication from the provider agency to the case manager. The Supervisory Monitoring Log will be completed monthly by agencies providing SPPC/AIDS Waiver services (not required for AIDS Waiver Supplies providers). The provider agency will record the number of authorized units as well as delivered units for each client for each service.

The Supervisory Monitoring Log will be submitted by the provider of care to the case manager by the **tenth (10th**) of the month following the month in which the service was delivered.

- If the log indicates more units were delivered than authorized, the case manager will refer to the Service Authorization, contact the provider, and clarify any differences. Units delivered in excess of authorized units will not be paid.
- If all authorized units were not delivered, the provider will provide an explanation of why units were not delivered as authorized. (ex: client not home, client in hospital, etc.)
- Provider documentation on the Supervisory Monitoring Log is required but should not be considered a substitution for regular contact and communication with the case manager.
- If a provider agency routinely fails to submit completed Supervisory Monitoring Logs within the specified timeframe, specified by BHSH, the agency may be disallowed as a provider for SPPC/AIDS Waiver services.

Monitoring Cost (Waiver Cost Cap)

DHSS will provide case managers with updated cost cap figures shortly after they are received each year. The case manager is responsible for contacting the Regional Quality Service Manager when a client is approaching the AIDS Waiver cost cap for the current fiscal year (fiscal year runs from July 1 - June 30). Approval *may* be given for continuing services if the statewide cumulative cost cap per client has not been reached. Costs for all clients will be averaged on a monthly basis to ensure that AIDS Waiver program costs do not exceed the yearly cost cap for all clients combined. If there is a concern that the total combined yearly cost caps may be exceeded, DHSS will work with DSS and case managers to identify solutions.

Recommended Client Contact Schedule*

	Initial Contact/ Annual Update	**Six-Month Update**	**Type and Frequency of Contact**	**Change in Condition**
SPPC/ AIDS Waiver Contact Schedule	Face-to-Face/Home Visit	Face-to-Face/Home Visit	Bi-Annual Home Visit and Quarterly Telephone Contact *(more frequent contact if warranted by client's condition)*	Face-to-Face/Home Visit

*The contact schedule above reflects best practices for HIV Medical Case Management in order to encourage the client to reach an optimal level of function and mobility. The minimum standards outlined in the AIDS Waiver require contact annually or more frequently if warranted by a change in the client's condition.

RECOMMENDED DOCUMENTATION SCHEDULE FOR SPPC/WAIVER CLIENTS*

Frequency → Documentation ↓	**Initial Contact**	**Monthly/Other Frequency**	**Every 6 months**	**As Assessment Changes**	**Yearly**
HIVLOC & Personal Goals	**X**		**X**	**X**	**X**
SPPC/AIDS Waiver Clipping		**X** Clipping required at 3rd and 9th month			
Individual Service Authorization	**X**		**X**	**X**	**X**
SPPC/Waiver Service Authorization (1-6 months)	**X**		**X**	**X**	**X**
Service Activity Instructions	**X**		**X**	**X**	**X**
Supervisory Monitoring Log		**X** (monthly)			
Release of Information	**X**			**X**	**X**
Client Choice Statement	**X**		**X**	**X**	**X**
Notification of Change Letter	**X** Required when services are decreased, terminated, or denied			**X** Required when services are decreased, terminated, or denied	
All Other HIV Medical Case Management Forms are required as specified in the HIV Medical CM Manual	Refer to HIV Medical Case Management Manual	Refer to HIV Medical Case Management Manual	Refer to HIV Medical Case Management Manual	Refer to HIV Medical Case Management Manual	Refer to HIV Medical Case Management Manual

DISCHARGE POLICIES AND PROCEDURES FOR STATE PLAN PERSONAL CARE AND AIDS WAIVER SERVICES

Discontinuing services for a participant still in need of assistance shall occur only after appropriate conferences with the state agency or its designees, participant and participant's family.

Services for participants shall be discontinued by the state agency or its designee under the following circumstances:

- Death
- Are not eligible for MO HealthNet
- Do not need the Level of Care provided in a nursing facility
- Have not been diagnosed by a physician as having AIDS or HIV related illnesses
- Do not require at least one available service
- Cannot be safely maintained in the home environment
- Have committed a rule violation (fraud, threatening behavior, etc.)

Services for participants shall be discontinued by a provider under the following circumstances:

- When the participant's case is closed by the state agency of its designee:
- When the provider learns of circumstances that require that closure of a case for reasons including, but not limited to: death; entry into a nursing facility; or the participant no longer needs services. In these circumstances, the provider shall notify the state agency or its designee in writing and request that the participant's services be discontinued;
- When the participant is noncompliant with the agreed upon care plan. Noncompliance requires persistent actions by the participant, friends, or family which negate the services delivered by the provider. After all alternatives have been explored and exhausted, the provider shall notify the state agency or its designee, in writing, of the noncompliant acts and request that the participant's services be discontinued;
- When the participant or participant's family demonstrates threatening or violent behavior to the point where the staff's welfare is in jeopardy and corrective action has failed. Services may be discontinued if the identification of an environmental health concern is present. The provider shall notify that state agency or its designee of the threatening or abusive acts or environmental health concern and may request that the service authorization be discontinued.
- When a provider is unable to continue to meet the maintenance needs of a participant. In these circumstances, the provider shall notify the state agency or its designee, in writing, and request that the participant's services be discontinued; or
- When a provider is unable to continue to meet the maintenance needs of a participant or when a participant is noncompliant with the agreed upon care plan, the provider shall provide written notice of discharge **or** the participant or participant's family and the state agency or its designee, at least 10 days prior to the date of discharge. During this 10 day

period, the state agency or its designee shall assist in making appropriate arrangements with the participant for transfer to another provider, institutional placement, or other appropriate care. Regardless of circumstances, the personal care provider must continue to provide care in accordance with the plan of care for these 10 days or until alternate arrangements can be made by the state agency, or its designee, whichever comes first.

DISCHARGE FROM STATE PLAN PERSONAL CARE OR AIDS WAIVER PROGRAM

To document the closing of a client to State Plan Personal Care or AIDS Waiver Program, enter zeroes in the 'revised' and 'delivered' column of the Service Authorization and scan into SCOUT. Please indicate in the comments section a reason for the closure. Notify the SPPC/AIDS Waiver Liaison to remove the client from active program status. Indicate the date of discharge, and if the case was closed due to client request or "other," indicate a reason. Enter a summary discharge note in the progress notes.

If the client is being closed for any of the above reasons other than spenddown or death, a Notification of Change Letter, on agency letterhead, must be sent to the client. In circumstances in which services are reduced or terminated, the client must be notified by mail at least ten (10) days before the date of the action, except as permitted under 42 CFR 431.213 and 42 CFR 431.214 before services can be discontinued.

The service referral for SPPC and/or Waiver will have the end date changed to the date of discharge.

NOTE: Before a hold on services can be approved, the Case Manager, QSM and State Plan Personal Care/AIDS Waiver Liaison, will need to develop a plan of action for the participant, to include: why the hold is necessary, the duration of the hold, possible discharge from services etc.

HIV Level of Care Assessment (HIVLOC)

The HIV Specialty Level of Care (HIVLOC) instrument is used to determine a client's institutional level of care.

- To be eligible for State Plan Personal Care services, an individual must require care at a Nursing Facility level. The total points must be assessed at 18, or greater (equal or greater to the current State of Missouri Nursing Home Level of Care) on the assessment
- To be eligible for AIDS Waiver Services, an individual must require care at a Nursing Facility level. The total points must be assessed at 18 or greater (equal or greater to the current State of Missouri Nursing Home Level of Care) on the assessment and must include a minimum of two (2) medical criteria

The HIVLOC must be completed a minimum of twice a year, or with any changes due to the unstable nature of HIV disease as well as the overall goal of encouraging the client to reach his/her optimal level of function and mobility.

Note: Due to FMAP funding, beginning November 1, 2021 to November 1, 2024, if a participant does **not** meet criteria under the current HIVLOC, scoring 18 points or higher, the participant must be screened using the previous HIVLOC and score 24 points or higher.

Section A- Complete general participant information items.

Section B- Select the reason for the assessment.

Section C- Review and complete each component to assess participant needs and level of care.

As specified in 19 CSR 30-81.030, the following criteria are used to evaluate and reevaluate whether an individual meets a Nursing Facility level of care.

Behavioral: 0 to 9 points

- Determine if the participant:
  - Receives monitoring for a mental condition
  - Exhibits one of the following mood or behavior symptoms – wandering, physical abuse, socially inappropriate or disruptive behavior, inappropriate sexual behavior or public disrobing; resists care
  - Exhibits one of the following psychiatric conditions – abnormal thoughts, delusions, hallucinations

Cognitive: 0 to 18 points

- Determine if the participant has an issue in one or more of the following areas:
    - Cognitive skills for daily decision making
    - Memory or recall ability (short-term procedural, situational memory)
    - Disorganized thinking/awareness – mental function varies over the course of the day
    - Ability to understand others or to be understood

Mobility: 0 to 18 points

- Determine if the participant's primary mode of locomotion
- Determine the amount of assistance the participant needs with:
    - Locomotion – how moves walking or wheeling, if wheeling how much assistance is needed once in the chair
    - Bed Mobility – transition from lying to sitting, turning, etc.

Eating: 0 to 18 points

- Determine the amount of assistance the participant needs with eating and drinking. Includes intake of nourishment by other means (e.g. tube feeding or TPN).
- Determine if the participant requires a physician ordered therapeutic diet

Toileting: 0 to 9 points

- Determine the amount of assistance the participant needs with toileting. Toileting includes: using the toilet (bedpan, urinal, commode), changing incontinent episodes, managing catheters/ostomies, and adjusting clothing
- Determine the amount of assistance the participant needs with transferring on/off the toilet

Bathing: 0 to 6 points

- Determine the amount of assistance the participant needs with bathing. Bathing includes: taking a full body bath/shower and the transferring in and out of the bath/shower.

Dressing and Grooming: 0 to 6 points

- Determine the amount of assistance the participant needs with:
    - Personal Hygiene
    - Dressing Upper Body
    - Dressing Lower Body

Rehabilitation: 0 to 9 points

- Determine if the participant has the following medically ordered therapeutic services:
    - Phsyical Therapy
    - Occupational Therapy

- Speech-language pathology and audiology services
- Cardiac rehabilitation

Treatment: 0 to 6 points

- Determine if the participant requires any of the following treatments:
  - Catheter/Ostomy care
  - Alternate modes of nutrition (tube feeding, TPN)
  - Suctioning
  - Ventilator/respirator
  - Wound care (skin must be broken)

Meal Prep: 0 to 6 points

- Determine the amount of assistance the participant needs to prepare a meal. This includes planning, assembling ingredients, cooking, and setting out the food and utensils

Medication Management: 0 to 6 points

- Determine the amount of assistance the participant needs to safely manage their medications. Assistance may be needed due to a physical or mental disability

Safety: 0 to 18 points

- Determine if the individual exhibits any of the following risk factors:
  - Vision Impairment
  - Falling
  - Balance – moving to standing position, turning to face the opposite direction, dizziness, or unsteady gait.
- After determination of preliminary score, history of institutionalization in the last five years and age will be considered to determine the final score
  - Institutionalization – long term care facility, RCF/ALF, mental health residence, pshyciatric hospital, inpatient substance abuse, settings for persons with intellectual disabilities
  - Age – 75 years and over

HIV Level of Care Assessment Scoring Instructions:

This document serves as a summary of the DRAFT LOC Algorithm 2.2 which determines a participant's Nursing Facility Level of Care (LOC). The DRAFT LOC Algorithm 2.2 should be used to determine a participant's LOC. However, this guide serves as a blueprint for stakeholders and participants to understand proposed LOC updates.

BEHAVIORAL:

- Determine if the participant:
  - Receives monitoring for a mental condition
  - Exhibits one of the following mood or behavior symptoms – wandering, physical abuse, socially inappropriate or disruptive behavior, inappropriate public sexual behavior or public disrobing; resists care
  - Exhibits one of the following psychiatric conditions –abnormal thoughts, delusions, hallucinations

0 pts	3 pts	6 pts	9 pts	18 pts
Stable mental condition **AND** No mood or behavior symptoms observed **AND** No reported psychiatric conditions	Stable mental condition monitored by a physician or licensed mental health professional at least monthly **OR** Behavior symptoms exhibited in past, but not currently present **OR** Psychiatric conditions exhibited in past, but not recently present	Unstable mental condition monitored by a physician or licensed mental health professional at least monthly **OR** Behavior symptoms are currently exhibited **OR** Psychiatric conditions are recently exhibited	Unstable mental condition monitored by a physician or licensed mental health professional at least monthly **AND** Behavior symptoms are currently exhibited **OR** Psychiatric conditions are currently exhibited	

COGNITION:

- Determine if the participant has an issue in one or more of the following areas:
  - Cognitive skills for daily decision making
  - Memory or recall ability (short-term, procedural, situational memory)
  - Disorganized thinking/awareness – mental function varies over the course of the day
  - Ability to understand others or to be understood

0 pts	3 pts	6 pts	9 pts	18 pts
No issues with cognition **AND** No issues with memory, mental function, or ability to be understood/understand others	Displays difficulty making decisions in new situations or occasionally requires supervision in decision making **AND** Has issues with memory, mental function, or ability to be understood/understand others	Displays consistent unsafe/poor decision making or requires total supervision **AND** Has issues with memory, mental function, or ability to be understood/understand others	Rarely or never has the capability to make decisions **OR** Displays consistent unsafe/poor decision making or requires total supervision **AND** rarely or never understood/able to understand others	TRIGGER: Comatose state

EATING:

- Determine the amount of assistance the participant needs with eating and drinking. Includes intake of nourishment by other means (e.g. tube feeding or TPN).
- Determine if the participant requires a physician ordered therapeutic diet

0 pts	3 pts	6 pts	9 pts	18 pts
No assistance needed **AND** No physician ordered diet	Physician ordered therapeutic diet **OR** Set up, supervision, or limited assistance needed with eating	Moderate assistance needed with eating, i.e. **participant** performs more than 50% of the task independently	Maximum assistance needed with eating, i.e. participant requires **caregiver** to perform more than 50% for assistance	TRIGGER: Total dependence on others

MOBILITY:

- Determine the participant's primary mode of locomotion
- Determine the amount of assistance the participant needs with:
  - Locomotion – how moves walking or wheeling, if wheeling how much assistance is needed once in the chair
  - Bed Mobility – transition from lying to sitting, turning, etc.

0 pts	3 pts	6 pts	9 pts	18 pts
No assistance needed **OR** Only set up or supervision need	Limited or moderate assistance needed, i.e. **participant** performs more than 50% of task independently	Maximum assistance needed for locomotion or bed mobility, i.e. participant needs 2 or more helpers or more than 50% of caregiver weight-bearing assistance **OR** Total dependence for bed mobility		TRIGGER: Participant is bedbound **OR** Total dependence on others for locomotion

TOILETING:

- Determine the amount of assistance the participant needs with toileting. Toileting includes: using the toilet (bedpan, urinal, commode), changing incontinent episodes, managing catheters/ostomies, and adjusting clothing.
- Determine the amount of assistance the participant needs with transferring on/off the toilet

0 pts	3 pts	6 pts	9 pts	18 pts
No assistance needed **OR** Only set up or supervision needed	Limited or moderate assistance needed, i.e. **participant** performs more than 50% of task independently	Maximum assistance needed, i.e. participant needs 2 or more helpers or more than 50% of caregiver weight-bearing assistance	Total dependence on others	

BATHING:

- Determine the amount of assistance the participant needs with bathing. Bathing includes: taking a full body bath/shower and the transferring in and out of the bath/shower.

0 pts	3 pts	6 pts	9 pts	18 pts
No assistance needed **OR** Only set up or supervision needed	Limited or moderate assistance needed, i.e. **participant** performs more than 50% of task independently	Maximum assistance, i.e. participant needs 2 or more helpers or more than 50% of caregiver weight-bearing assistance **OR** Total dependence on others		

DRESSING AND GROOMING:

- Determine the amount of assistance the participant needs with:
  - Personal Hygiene
  - Dressing Upper Body
  - Dressing Lower Body

0 pts	3 pts	6 pts	9 pts	18 pts
No assistance needed **OR** Only set up or supervision needed	Limited or moderate assistance needed, i.e. **participant** performs more than 50% of task independently	Maximum assistance, i.e. participant needs 2 or more helpers or more than 50% of caregiver weight-bearing assistance **OR** Total dependence on others		

R**EHABILITATION:**

- Determine if the participant has the following medically ordered therapeutic services:
  - Physical therapy
  - Occupational therapy
  - Speech-language pathology and audiology services
  - Cardiac rehabilitation

0 pts	3 pts	6 pts	9 pts	18 pts
None of the above therapies ordered	Any of the above therapies ordered, 1 time per week	Any of the above therapies ordered 2-3 times per week	Any of the above therapies ordered 4 or more times per week	

TREATMENTS:

- Determine if the participant requires any of the following treatments:
  - Catheter/Ostomy care
  - Alternate modes of nutrition (tube feeding, TPN)
  - Suctioning
  - Ventilator/respirator
  - Wound care (skin must be broken)

0 pts	3 pts	6 pts	9 pts	18 pts
None of the above treatments needed		One or more of the above treatments are needed		

MEAL PREP:

- Determine the amount of assistance the participant needs to prepare a meal. This includes planning, assembling ingredients, cooking, and setting out the food and utensils.

0 pts	3 pts	6 pts	9 pts	18 pts
No assistance needed **OR** Only set up or supervision needed	Limited or moderate assistance needed, i.e. **participant** performs more than 50% of task	Maximum assistance, i.e. **caregiver** performs more than 50% of task **OR** Total dependence on others		

MEDICATION MANAGEMENT:

- Determine the amount of assistance the participant needs to safely manage their medications. Assistance may be needed due to a physical or mental disability.

0 pts	3 pts	6 pts	9 pts	18 pts
No assistance needed	Setup help needed **OR** Supervision needed **OR** Limited or moderate assistance needed, i.e. **participant** performs more than 50% of task.	Maximum assistance needed, i.e. **caregiver** performs more than 50% of task **OR** Total dependence on others		

Safety

- Determine if the individual exhibits any of the following risk factors:
  - Vision Impairment
  - Falling
  - Balance – moving to standing position, turning to face the opposite direction, dizziness, or unsteady gait
- After determination of preliminary score, history of institutionalization in the last 5 years and age will be considered to determine final score:
  - Institutionalization – long term care facility, RCF/ALF, mental health residence, psychiatric hospital, inpatient substance abuse, settings for persons with intellectual disabilities
  - Age – 75 years and over

0 pts	3 pts	6 pts	9 pts	18 pts
No difficulty or some difficulty with vision **AND** No falls in last 90 days **AND** No recent problems with balance *Age	Severe difficulty with vision (sees only lights and shapes) **OR** Has fallen in last 90 days **OR** Has current problems with balance **OR** Preliminary score of 0 **AND** Age or Institutionalization	No vision **OR** Has fallen in last 90 days **AND** Has current problems with balance **OR** Preliminary score of 3 **AND** Age **OR** Institutionalization	Preliminary score of 6 **AND** Institutionalization	TRIGGER Preliminary score of 6 **AND** Age **OR** Preliminary score of 3 **AND** Age **AND** Institutionalization

Section D- Indicate participant's medical criteria; complete for AIDS Waiver only. AIDS Waiver participants must have a minimum of two medical criteria.

1. Multi-organ failure (ex. Liver, kidney, heart, pancreas, lung)
2. Support to maintain vital function and/or maintain complex IV therapy, peripheral nutrition, central venous catheters, daily diabetic blood sugar tests, and insulin injection.
3. Assessment and assistance with pain control and/or pain therapy during an acute and terminal phase of an illness.
4. Oversight as related to dementia, and/or severe chronic and persistent mental illness (ex. Bipolar, multiple suicide attempts, schizophrenia, and confusion)
5. Oversight related to a terminal phase of an illness.
6. Licensed nursing care on a regular basis to assist in recovering from opportunistic infections and/or acute illnesses.
7. Weekly monitoring required by a licensed nurse and/or physician in order to provide assessment for opportunistic infection (CD4, VL, signs, and symptoms).
8. Licensed nursing care on a regular basis to assist with medication set up, adherence, and monitoring for serious side effects.
9. Monitoring and assistance to maintain safety/optimum mobility related to neurological deficits (ex. Neuropathy or uncontrolled seizures).
10. Oversight as a result of comorbid complications (ex. Substance abuse, secondary disease processes, TB, and hepatitis).

Section E- Document Level of Care score (total of Section C) and Medical Criteria score. Indicate whether client should be referred to SPPC, AIDS Waiver, and/or Other Programs.

CLIENT CHOICE STATEMENT

Client Choice Statement

The purpose of the HIV/AIDS Client Choice Statement is to assure the client is aware that they may choose:

- SPPC/AIDS Waiver services or a nursing home facility;
- who participates in Service Authorization development;
- the types of services they may be eligible to receive;
- a MO HealthNet approved provider;
- residential Care Facility (RCF) - Doorways

The Client Choice Statement also addresses the Statewide Transition Plan. It assures that the client is aware that they have the right to receive SPPC/AIDS Waiver services in settings that are integrated and support full access to the greater community.
This includes opportunities to:

- Seek employment and work in competitive and integrated settings;
- Engage in community life;
- Control personal resources; and
- Receive services in the community to the same degree as individuals who do not receive SPPC/AIDS Waiver services.

Upon enrollment, the HIV/AIDS Client Choice Statement must be completed before the SPPC/AIDS Waiver services can be authorized. The case manager will discuss the assessment findings with the client to determine services needed. Additionally, they will discuss the client's goals and ways to reach them, either through the services the waiver will provide or other avenues. The Ryan White Case Management System goal of establishment and/or maintenance of medical care will always guide decisions. The appropriateness of the Service Authorization and desire to continue services are readdressed at the time of each assessment and reassessment.

A new client choice form must be completed when:

- A client is readmitted to State Plan Personal Care or AIDS Waiver services if inactivated for any reason other than an interruption in MO HealthNet eligibility due to spenddown not being met for the month.
- Every 6 months
- At annual updates
- Initial Intake

FORM COMPLETION

- Enter the client's name and Departmental Client Number (DCN) at the top of the page.
- Explain the nursing facility alternative to in-home services to the client and check the box reflecting the client's choice to receive State Plan Personal Care or AIDS Waiver services.
- Explain to the client they have a choice of any approved MO HealthNet provider.
- Explain to the client that they have a choice between institutional care and waiver services.
- Explain to the client that they have a choice of who participates in the development of their Service Authorization.
- Review the appeal rights and client grievance process with the client or legal representative.
- The client or legal representative must sign and date the form at the bottom of the page.
- A copy of the client choice statement is left with the client, and the signed and dated copy is scanned into the client's document log.

SERVICE ACTIVITY INSTRUCTIONS

The purpose of the completion of the Service Activity Instructions form is to document and verify, with the provider agency, the services to be provided, the frequency of the services, the duration of care, and any other instructions. The Service Activity Instructions are completed when State Plan Personal Care (Basic Personal Care, Advanced Personal Care and Authorized Nurse Visit) and AIDS Waiver (Waiver Personal Care, Attendant Care, and Private Duty Nursing) services are authorized. Service Activity Instructions are completed and sent to the provider agency, for signature. Please note that all blanks must be completed with appropriate information or "NA." The Service Activity Instructions will then be scanned into the SCOUT system.

FORM COMPLETION

- **CLIENT INFORMATION**
  Enter the client's name, Departmental Client Number (DCN), address, telephone number.
- **CONTACT INFORMATION**
  Enter the contact's name, relationship, and phone number complete with accurate/current information. If no emergency contact available, fill in the fields with N/A.
- **PHYSICIAN NAME**
  Enter the HIV care provider's name and telephone number.
- **PROVIDER NAME**
  Enter the provider agency name and telephone number.
- **PERIOD OF ELIGIBILITY**
  The period of eligibility is the same period of eligibility established on the SPPC/Waiver Participant Service Authorization.
- **FREQUENCY**
  Enter the frequency of authorized services, include days and times.
- **SERVICES**
  Check only the boxes beside the services to be provided. Do not automatically check all boxes. Services not available under State Plan Personal Care are indicated by a (*).
- **COMMENT/DIRECTIONS TO CLIENT'S HOME**
  Enter comments, directions, or any safety concerns as needed.
- **CASE MANAGER SIGNATURE/DATE**
  The case manager must sign and date the form.
- **PROVIDER SIGNATURE/DATE**
  The provider must sign and date the form.

A signed and dated copy of the Service Activity Instructions shall be scanned into the Document log. A copy of the form shall also be provided to the provider agency.

SPPC/ WAIVER PARTICIPANT SERVICE AUTHORIZATION

The Service Authorization is developed after the client and case manager have agreed on services, and the client has made provider choices. Service authorizations for Basic Personal Care, Advanced Personal Care, and the AIDS Waiver program can be developed for one to six months at a time. The Service Authorization lists all services by month, the number of units of service, and cost for each service (*except* Basic Personal Care, Authorized Nurse Visits, and Advanced Personal Care). The Service Authorization must include the dollar amount of the services authorized under the AIDS Waiver Program (Waiver Personal Care, Attendant Care, Private Duty Nursing, and Supplies).

It is the responsibility of the case manager authorizing services to verify that:

- The client is MO HealthNet eligible during the time the services are to be provided,
- The client meets the level of care required (18 or greater) to receive State Plan Personal Care (SPPC) services,
- The client meets the level of care required (18 or greater), plus a minimum of two medical criteria to receive AIDS Waiver services.

Service Authorizations are developed in monthly increments. When going from one fiscal year to the next, a new Service Authorization must be completed and scanned into the Documents log. Services may be revised or added for the month by entering the date and the change or revision that is being made.

- Revisions will be made by:
- Indicating change or revision on the copy of the Service Authorization; or by
- Completing a new Service Authorization

FORM COMPLETION

- **CLIENT INFORMATION**
  Enter client information.
- **PROVIDER**
  Enter the name of the provider to whom the service is to be authorized.
- **MO HEALTHNET STATUS**
  Check the box for MO HealthNet eligibility pending, MO HealthNet eligibility, or if the client has a spenddown.
- **PLAN APPROVAL**
  Indicate if the Service Authorization is a New Enrollment, Six Month Update, and Increase/Decrease. If authorizing greater than 16 hours per day, must indicate QSM approval prior to authorization.
- **MONTH/YR**
  Enter the month/months/yr for which you are planning services.

- **SERVICE DESCRIPTION**
  Select the service description from the form.

State Plan Personal Care Services:

Basic State Plan Personal Care Aide (T1019)
Advanced Personal Care (T1019 TF)
State Plan Personal Care-Nurse Visit (T1001)

MO HealthNet Waiver Services:

Waiver Personal Care (T1019 U4)
Attendant Care (S5126 U4)
Private Duty Nursing (T1000 U4)
Waiver DME Supplies (T2028 U4 NU)

- **FREQUENCY**
  Enter the number of visits or hours to be provided during the Service Authorization period. Indicate the number of hours per day or week for Personal Care Services. When authorizing supplies under the AIDS Waiver Program, list the specific supply items.

- **UNITS/$ AMOUNT**
  Units per month are used to indicate the number of units **authorized** (Column **A**). If the case manager authorizes AIDS Waiver services, the number of units will be converted to a dollar amount of money and carried across to the corresponding program. When State Plan Personal Care (including nurse visits under SPPC) is authorized, no dollar amount will be used. Use column **R** to indicate **revised** units/$. Use Column **D** to indicate **delivered** units/$.

- **DATES** (first date of service, revised plan date, reconciled plan date)
  Enter the date that you start the Service Authorization. If you change the Service Authorization, the current date of that change is entered for each change. Enter the date for a revised plan and a reconciled plan date.

- **COMMENTS**
  Comments should be used to add any additional relevant information to the Service Authorization.

- **WAIVER COST (This Month)**
  If authorizing AIDS Waiver services, convert the units per month to a dollar amount. Enter the dollar amount in corresponding column under Waiver Cost (This Month). Dollar amounts should be totaled to indicate total cost per month for supplies. Dollar amounts total automatically if form is completed electronically.

- **ACTUAL DELIVERED COST (Cumulative)**
  Enter the cumulative delivered cost from previous Service Authorization for FY (July 1-June 30). Cumulative costs total automatically if the form is completed electronically.

- **TOTAL COST TO DATE**
  Enter the dollar amount of AIDS Waiver services being authorized for that month. The total cost to date totals automatically if the form is completed electronically.

- **CASE MANAGER SIGNATURE**
  The Service Authorization needs to be signed by the authorizing case manager prior to the first date the actual service is delivered by the agency. Enter the case management agency/region.

- **QSM APPROVAL**
  QSM shall sign and date the Service Authorization at their earliest convenience and scan the official, signed document into the document module. **Services indicated on the Service Authorization may not be authorized until the QSM has signed the Service Authorization**.

- **REVISED SIGNATURE**
  The Service Authorization must be signed by the Case Manager and then QSM for any revisions made to the Service Authorization.

A new Service Authorization, including Quality Service Manager approval, is completed every six months or under the following circumstances:

- When new services are implemented
- When there has been a Service Authorization revision
- When the client has been discharged and then reenrolled to the program

The Service Authorization must be signed by the Case Manager and the QSM. If the QSM in your region is not available, please contact a QSM in one of the other regions. If calling Jefferson City, please advise whoever answers the phone that you need to get in touch with a QSM for plan approval.

Notify SPPC/Waiver Liaison, through a Communicate in SCOUT, that a Service Authorization has been scanned into the documents log. If changes or revisions are made, the case manager will scan in revised/new Service Authorization. A copy must remain in SCOUT and must reflect all revisions.

The SPPC/AIDS Waiver Liaison will then print off a copy of the Services Authorization and complete a Prior Authorization for services, which will then be sent to MO HealthNet for final approval.

Prior authorization of services to a provider allows payment for services when they are billed. **It does not guarantee payment.** No services should be provided until the prior authorization process has been completed.

SUPERVISORY MONITORING LOG

The purpose of the Supervisory Monitoring Log is to provide follow up information to the case manager regarding services rendered by the provider agency. If all authorized units of care are not delivered, a reconciliation reflecting the non-delivery of care allows funds to be reallocated and fully utilized to serve other clients. It also provides documentation to the case manager and Quality Service Manager when a provider has not met their obligations.

The Supervisory Monitoring Log is completed monthly by agencies providing Basic Personal Care, Advanced Personal Care, Authorized Nurse Visit, Waiver Personal Care, Attendant Care, and Private Duty Nursing services. The provider agency should record the number of authorized units, as well as delivered units for each client, for each service. The agency will list:

- The number of authorized units for each client and for each service authorized; and
- The number of delivered units for each client and for each service authorized

Differences between the number of units authorized and delivered must be explained in the comment section (i.e., hospitalization).

- The Supervisory Monitoring Log must be sent to the case manager by the **10th of the month** following the month services were delivered. Monthly summary notes of care activities must be submitted. These notes may be attached to the Supervisory Monitoring Log.

If the provider does not submit the Supervisory Monitoring Log by the 10 of the month, the following steps will be taken:

- CMs and QSMs are responsible for ensuring all documents are uploaded into SCOUT.
- If a supervisor's log is missing, the CM is to request the log be submitted **within one (1) business day** from the provider agency.
    - If the documentation is submitted and uploaded into SCOUT, then no further action is needed.
    - If the provider agency **does not** submit the requested documentation **within one (1) business day**, the CM is to inform the QSM via e-mail of the outstanding request.
- The QSM will contact the provider agency only if the provider agency is unresponsive to the CM's request. The QSM is to request the log be submitted **within one (1) business day**.
    - If the documentation is submitted and uploaded into SCOUT, then no further action is needed.
    - If the provider agency **does not** submit the requested documentation **within one (1) business day**, the QSM is to inform the State Plan Personal Care/AIDS Waiver Liaison via e-mail of the outstanding request.

- The State Plan Personal Care/AIDS Waiver Liaison will contact the provider agency only if the provider agency is unresponsive to the QSM's request. The State Plan Personal Care/AIDS Waiver Liaison is to request the log be submitted **within one (1) business day**.
    - If the documentation is submitted and uploaded into SCOUT, then no further action is needed.
    - If the provider agency **does not** submit the requested documentation **within one (1) business day**, the State Plan Personal Care/AIDS Waiver Liaison will coordinate with the Director of HIV Case Management on the next steps.

Note: All attempts to collect required audit information must be documented in SCOUT. Provider agencies, CMs, or QSMs with performance measures below 86% will be required to complete Remediation and attend training. While training is offered annually, any agency provider, CM, or QSM may request training at any time. Training may be necessary for those who have issues with complying with audit requests, regardless of meeting the performance measure.

RECONCILIATION OF SERVICE AUTHORIZATION

The purpose of reconciliation is to compare the amount of services authorized with the amount actually delivered. Upon receipt of the Supervisory Monitoring Log, the case manager enters the number of units delivered next to the number of units authorized on the Service Authorization. Enter the corresponding dollar amounts for AIDS Waiver services. If the Supervisory Monitoring Log reflects a difference between units authorized and units delivered, the provider must document the reason for the discrepancy between units authorized and delivered. If the reason for the discrepancy is not documented, the case manager shall follow-up with the provider, client, and DHSS so that they can document actions, findings, and outcomes in the progress notes. Reconciled Service Authorizations shall be scanned into the documents log promptly after completion.

PRIOR AUTHORIZATION (PA) FOR MO HEALTHNET SERVICES

The prior authorization indicates whether a service is being initiated or revised (added or changed). The Case Managers complete and scan into SCOUT, the completed Service Authorization. The Case Manager will then notify the Regional QSM that there is an unsigned Service Authorization in SCOUT that needs to be approved. The QSM will sign the Services Authorization and then send the SPPC/AIDS Waiver Liaison a Communicate in SCOUT alerting that there is a Services Authorization in SCOUT that needs a prior authorization. The SPPC/AIDS Waiver Liaison will then complete the Prior Authorization and mail it out to Mo HealthNet. An Authorization Determination letter will then be computer-generated by Central Office. No services should be provided until the prior authorization process has taken place.

If changes or revisions in client services are necessary, the case manager will make changes to the original Service Authorization scan it into the documents log and notify the SPPC/AIDS Waiver Liaison that a change has been entered. The SPPC/AIDS Waiver Program Liaison will make changes to the Authorization Determination Letter and send it to MO HealthNet for entry.

AUTHORIZATION DETERMINATION (AD) LETTER

The Authorization Determination (AD) Letter is the provider's indication that services have been formally approved and that approval of prior authorization is reflected in Mo HealthNet's claims payment file. The SPPC/AIDS Waiver Liaison receives this letter from MO HealthNet and then scans a copy into the documents log of SCOUT.

NOTIFICATION OF CHANGE LETTER

The purpose of the Notification of Change Letter is to notify a client of their change in service status. The reason for the change and the client's appeal rights are specified in 42 CFR 431.200250.

A Notification of Change Letter will be sent if the client's State Plan Personal Care (SPPC) or AIDS Waiver Program services are reduced, terminated, or denied for any reason other than death or MO HealthNet eligibility interruption under MO HealthNet's Spenddown eligibility program. In circumstances in which services are reduced or terminated, the client must be notified by mail at least ten (10) days before the date of action, except as permitted under 42 CFR 431.213 and 42 CFR 431.214 before services can be discontinued.

The following page contains a sample letter, which must be adapted for the Provider Agency to use, utilizing the Provider Agency letterhead. **This is only a sample**. This letter **must** be personalized on your agency letterhead with the date, client inside address, salutation, and body of the letter individualized with the specific services reduced, terminated or denied, and the reason(s) indicated.

- Be sure you include the client's full legal name.
- Check the box indicating where services are reduced, terminated, or denied.
- List the reason(s) the client is ineligible for SPPC/AIDS Waiver services.
- Be sure the letter is signed prior to mailing.
- Send the original to the client. Place a copy in the client's record.

Date of Letter:	
Re: (Client's Name and Address)	Case Manager:
Department Client Number:	Case Manager's Phone:

Dear _____:

This is to advise you the following decision has been made concerning services through the State Plan Personal Care/AIDS Waiver Program. The request for the following service(s)

☐ AIDS Waiver
☐ Specialized Medical Supplies
☐ Attendant Care
☐ Waiver Personal Care
☐ Private Duty Nursing

☐ State Plan Personal Care:
☐ Basic Personal Care
☐ Advanced Personal Care
☐ Authorized Nurse Visit

has been ☐ reduced to_____ terminated ☐ denied for the following reason(s)

☐ No longer eligible for MO Healthnet effective _____
☐ Evaluation did not indicate that you needed the level of care provided in a hospital/nursing facility.
☐ No diagnosis by a physician as having HIV infection or AIDS disease.
☐ Do not require at least one available service.
☐ You cannot be safely maintained in your home environment, specifically

_____

Provider/staff environmental or safety concern, specifically

_____

☐ Other, Specify _____

- You have the right to appeal this decision as specified in 42 Code of Federal Regulations 431.200-250. If you wish to have services continued pending the hearing **decision, YOU MUST REQUEST THE HEARING WITHIN TEN (10) CALENDAR DAYS OF RECEIVING THIS LETTER**
  (Immediate discontinuation of services may occur for safety/environmental concerns for providers/staff).

You must **notify your case manager** as well as the MO HealthNet Division of your desire before the ten-day limit expires. If you do not request a hearing within (ten) 10 calendar days, services will discontinue. You will still have the right to appeal this decision within 90 calendar days from the date of this notice. You may do so by contacting the MO HealthNet Division, Recipient Services Unit, PO Box 6500, Jefferson City, MO, 65101-6500, by letter or in person, or by calling 1-800-392-2161.

- If you request a continuation of services during your appeal and are found to be ineligible for services at the time of the hearing, you,_____, **may be responsible for all fees and charges accrued for those services in the time between requesting a hearing and receiving the decision.**
- If you request a hearing, you may present your information yourself or be represented by your own attorney or other persons who have knowledge of your situation. If you do not have an attorney and cannot afford one and live in an area serviced by legal aid or a legal-services office, you may be eligible for free legal services. You have the right to present witnesses on your behalf and to question witnesses.

If you have any questions about this determination, you may contact your case manager listed in the box in the upper right corner of this page.

I agree with the reduction of services noted above, I have spoken with my case manager and concur with his/her Assessment.

Signature and date _____

FEDERAL REGULATION NOTICE OF CHANGE

§ 431.213 Exceptions from advance notice.

The agency may mail a notice not later than the date of action if –

(a) The agency has factual information confirming the death of a recipient;

(b) The agency receives a clear written statement signed by a recipient that—

(1) He no longer wishes services; or

(2) Gives information that requires termination or reduction of services and indicates that he understands that this must be the result of supplying that information;

(c) The recipient has been admitted to an institution where he is ineligible under the plan for further services;

(d) The recipient's whereabouts are unknown, and the post office returns agency mail directed to him indicating no forwarding address (See §431.231 (d) of this subpart for procedure if the recipient's whereabouts become known);

(e) The agency establishes the fact that the recipient has been accepted for Medicaid services by another local jurisdiction, State, territory, or commonwealth;

(f) A change in the level of medical care is prescribed by the recipient's physician;

(g) The notice involves an adverse determination made with regard to the preadmission screening requirements of section 1919(e)(7) of the Act; or

(h) The date of action will occur in less than 10 days, in accordance with §483.12(a) (5)(ii), which provides exceptions to the 30 days' notice requirements of §483.12(a) (5)(i).

[44 FR 17932, Mar. 29, 1979, as amended at 57 FR 56505, Nov. 30, 1992; 58 FR 25784, Apr. 28, 1993]

§ 431.214 Notice in cases of probable fraud.

The agency may shorten the period of advance notice to 5 days before the date of action if—

(a) The agency has facts indicating that action should be taken because of probable fraud by the recipient; and

The facts have been verified, if possible, through secondary sources.

PROVIDER NOTIFICATION OF CLIENT LETTER

A letter should be sent to providers when a new client is referred to them. The following is a sample letter, which could be adapted to your needs and put on your letterhead.

SAMPLE

DATE

NAME OF AGENCY
ADDRESS
CITY, STATE

Your agency has agreed to provide (type of service) for (first/last name of client). The following documents must be submitted in order to monitor the services provided by your agency:

- The Supervisory Monitoring Log must be attached and must be submitted to this office no later than the 10th of each month after giving services.
- An initial evaluation and Plan of Care.
- Monthly Summary Notes. These notes should be attached to the Supervisory Monitoring Log.

Please feel free to contact (case manager) at (case manager's phone number) if you have questions.

Sincerely,

Case Manager

CASE MANAGEMENT AUTHORIZATION FOR PERSONAL CLIENT MEDICAL/ HEALTH INFORMATION (PHI)

The purpose of the Case Management Authorization for Personal Client Health Information (PHI) form is to provide the case manager with the permission of the client to request copies of medical records from other service providers, clinics, hospitals, and physicians. These records will expand the knowledge of the case manager in order to more effectively assess and plan for the client's needs. A PHI should be completed in order to discuss client information with the provider agency.

FORM COMPLETION Enter the client information.

(Part A) AUTHORIZATION TO RELEASE PRIVATE HEALTH/MEDICAL INFORMATION (PHI)

(Part B) SERVICE PROVIDER

Enter the complete name and address of the provider from whom you are requesting records and complete the dates covering the periods of healthcare requested. The client must initial the specific information for release. Dates cannot exceed a twelve-month period. If hospital discharge summaries are requested, enter the date(s) of discharge. If other is checked, list records requested.

(Part C) SEND REQUESTED PERSONAL MEDICAL INFORMATION (PHI) TO:

Enter the name and address of your agency.

(Part D) ADDITIONAL INFORMATION

The client must initial where specified.

- Re-disclosure
- Alcohol and Drug Abuse Special Disclosure Information
- Time Limit and Revoke Authorization

(Part E) SIGNATURE OF CLIENT, PARENT, OR LEGAL GUARDIAN

The client, parent, or guardian must sign and date the form. The case manager or another person may sign as the witness. Be sure the date and position of title are entered for the witness.

(Part F) NOTICE OF REVOCATION

If the client wishes to revoke his authorization of this disclosure of information to the agency/person listed, part E must be signed and dated. A witness must also sign and date this form, and it must be given to the case manager, who will then sign and date it.

HIV CASE MANAGEMENT QUALITY IMPROVEMENT

INTRODUCTION

Quality Assurance and Continuous Quality Improvement Systems for State Plan Personal Care (SPPC) and AIDS Waiver Services

The Department of Health and Senior Services (DHSS), Bureau of HIV, STD, and Hepatitis has a formal quality improvement program. The Quality Service Managers (QSM) (Registered Nurses or Licensed Clinical Social Workers) oversee different regions of the state. The role of these positions is to ensure continuous quality improvement in the HIV Case Management system, specifically State Plan Personal Care and AIDS Waiver services.

Quality Assurance (QA):
Quality assurance refers to the activities that provide evidence to establish confidence that basic standards are met in the HIV Case Management program. This is accomplished through contract monitoring, chart monitoring, tracking and trending of occurrences, home and provider visits, education and training, and the establishment of standards of care.

Continuous Quality Improvement (CQI):
Based on the principles of quality assurance and continuous quality improvement, the following assurances are provided for the HIV Case Management, MO HealthNet State Plan Personal Care (SPPC), and AIDS Waiver program administration.

Assurances:

1. HIV Case Management is available for HIV+ Missouri residents and provided based on standards of care.
2. Provider standards and health and welfare safeguards have been developed and implemented and are under continuous review. This includes standards and guidelines applicable to the providers involved in the direct delivery of in-home services and case managers involved in the assessment, eligibility determination, and authorization of State Plan Personal Care and AIDS Waiver Services.
3. Providers of waiver services and case management services are provided with training opportunities.

Training, monitoring processes, corrective action measures, and other methods are employed to ensure that standards and requirements necessary for the delivery of services and administration of quality HIV Case Management are maintained.

MEASURES TO ENSURE PROVIDER QUALITY ASSURANCE AND IMPROVEMENT

Provider Eligibility

The MO HealthNet Division enrolls providers and verifies eligibility and capacity for delivery of State Plan Personal Care (SPPC) and AIDS Waiver services. The MO HealthNet Division provides a listing of qualified AIDS Waiver providers to the Department of Health and Senior Services. This list is then measured against the provider list that the SPPC/AIDS Waiver Liaison and QSM's have developed. The final list is then distributed to the Department of Health and Senior Services contracted case management staff. They will then use this list of AIDS Waiver certified, and MO HealthNet approved providers when offering clients a choice of providers and making referrals for AIDS Waiver care.

Provider Training

Provider training sessions, joint provider meetings with case management staff, and ongoing technical assistance are delivered by the Department of Health and Senior Service's Quality Service Managers (QSM) to ensure the following:

- Providers have a clear understanding of the policies and limits of guidelines associated with the State Plan Personal Care/AIDS Waiver.
- Providers are trained and instructed in forms completion and reporting requirements associated with the MO HealthNet AIDS Waiver, such as the *Supervisory Monitoring Log*.
- Providers and case management staff are instructed regarding the importance of collaboratively monitoring clients' conditions and the need to communicate any shifts or changes that may necessitate a change in clients' plans of care.
- As negative trends or patterns in provider submission of documentation associated with the delivery and billing for care occur, the Department of Health and Senior Service's Quality Service Managers offer technical assistance to resolve these issues as they occur.

MEASURES TO ENSURE CASE MANAGER QUALIFICATIONS AND TRAINING

The following measures are used to ensure that contracted case managers are successful in the assessment, plan implementation, documentation, and evaluation of clients' needs for State Plan Personal Care (SPPC)/AIDS Waiver services.

- **SPPC/Waiver Case Manager Qualification Requirements:** Contracts require waiver case managers to be a Licensed Clinical Social Worker (L.C.S.W.), Master of Social Work (M.S.W.), or Registered Nurse (R.N.). Attendance of mandatory Waiver training prior to case managing SPPC/AIDS Waiver clients is a component of the contract to ensure only trained, qualified staff, authorize SPPC/AIDS Waiver services. Yearly training must be completed to assure the ongoing quality of care. Contracts place financial liability for accurate, appropriate authorization of SPPC/AIDS Waiver services with the contractor.

- **MO HealthNet SPPC/AIDS Waiver Training Materials:** Training materials and the SPPC/AIDS Waiver manual, were developed as an adjunct to the HIV Medical Case Management Manual. General training sessions are held at the local level so that all case managers will have a clear understanding of the availability of SPPC/AIDS Waiver services and are able to identify clients who might medically qualify for MO HealthNet SPPC/AIDS Waiver services. SPPC/AIDS Waiver trainings are conducted each year for case managers. Technical assistance is provided to new Waiver case managers in all regions.

- **Monitoring of Service Authorizations and Written Authorizations:** Service Authorizations are reviewed and approved by the regional Quality Service Manager. The Service Authorizations are reviewed for validity by the SPPC/AIDS Waiver Liaison prior to being sent forward to MO HealthNet.

STATE PLAN PERSONAL CARE/AIDS WAIVER CLIENT CHART MONITORING

It is the policy of the Department of Health and Senior Services to have an ongoing review of State Plan Personal Care/AIDS Waiver charts. The SPPC/AIDS Waiver Liaison monitors 100% of AIDS Waiver charts, annually, and provides results of the audits on a quarterly basis to, MO HealthNet Division Program Operation staff. All MO HealthNet AIDS Waiver charts are reviewed in the course of the fiscal year, and a quarterly quality assurance report of findings and corrective action plans are provided to MO HealthNet Division. These chart reviews are conducted to identify strengths and weaknesses and to help in planning quality improvement programming for case managers. A record review tool for case management is used for chart monitoring to assure the client meets the criteria necessary for authorization of theses personal care and nursing services. Summary of these record reviews are provided to case managers and their supervisors.

No less than annually, MHD Program Operation staff and DHSS program oversight staff meet to discuss audit findings, as well as the Quality Improvement Strategy, outlined in the AIDS Waiver. At this time, DHSS program oversight staff and MHD Program Operations staff jointly review the performance measures and analyze corresponding reports generated by both agencies. MHD and DHSS review the outcome of the reports to ensure they are meeting the assurances specified throughout the application and what, if any, action may be necessary for remediation and or system improvement.

Systemic errors and trends are identified by MHD and DHSS based on the reports for each performance measure using the number and percent of compliance. Recommendations for system change may come from either agency; however, MHD will approve any changes to the Quality Improvement Strategy specified in the waiver application. Any changes in the Quality Improvement Strategy in the waiver application are implemented and monitored, as appropriate.

System improvement activities related to participant health, welfare, and safety are the first priority for MHD and DHSS staff. Additional priorities are established based on the number and percent of compliance specified in the waiver reports for the Quality Improvement Strategy in the waiver.

Although individual problems are remediated upon discovery, performance measures that are significantly lower than 100% may need to be addressed as a systemic issue. DHSS has a Remediation Plan to address any issues found when completing chart audits. This plan has been approved by MHD and implemented. System change related to delegated activities will be the responsibility of DHSS, and those activities that are not delegated will be the responsibility of MHD. Follow-up discussions related to system improvement activities may be discussed at quarterly meetings but will be discussed no less than annually.

Systemic issues may require follow-up reports, policy and or procedure changes, as well as staff and/or provider training MHD and DHSS, will analyze the effectiveness of system improvement activities through the Quality Improvement Strategy reports and or additional reports that may be recommended by DHSS and/or MHD when significant areas of concern are identified.

DHSS/MHD Co-Monitoring of Client Charts

DHSS participates in annual co-monitoring of AIDS Waiver client charts with the Department of Social Services/MO HealthNet Division. This is a collaborative effort between DHSS and MO HealthNet to ensure assurances are being met as outlined in the AIDS Waiver.

INCIDENT REPORT

The Department of Health and Senior Services has developed an Incident Report form to document incidents and other concerns. Information gathered will track occurrences and identify trends to promote quality assurance and improvement. The completed form will be forwarded to the DHSS Director of HIV Case Management. This form is to be used to document all hotline calls.

Incident Report forms are not part of the client record and need to be maintained in a separate file. No reference should be made to the report in the client record. Encounter/ Progress notes should continue to contain objective documentation of significant issues related to the reports.

INCIDENT/QUALITY MANAGEMENT REPORT INSTRUCTIONS

1. Indicate REGION by checking one choice
2. Enter in the Date of Report
3. Name of Reporter or person filling out the form
4. Date(s) of incident or date incident occurred
5. Reporting Agency or agency reporting incident
6. Indicate the type of program referenced in the report (i.e., Case Management, SPPC/Waiver, RW Support Services, Specialty Case Management, RW Statewide Services, Vendor/Provider for HIV Program) by checking a box.
7. Indicate the type of incident/quality concern (i.e., Quality of Care, Access to Care, Aggressive Behavior/Action toward Staff or Client, Health or Safety Risk for Staff or Client, Customer Service, Theft/Financial Loss/Fraud, Violation of Confidentiality, Medication or Prescription Error, Destruction of Property, Abuse/Neglect, Other) by checking a box.
8. Enter that name of Client(s) included in the report
9. Enter the name of the Staff Person(s) included in the report
10. Enter the name of the Provider(s) included in the report
11. Enter any Other Entities included are in the report
12. Provide a Detailed Description of the Incident (who, where, why, how)
13. Enter the action taken and by whom, recommendations, outcomes in the Agency Action/Supervisor Follow - Up note (optional)
14. Signature of whoever is completing the form is required
15. Date the form was completed is required
16. Enter the action taken and by whom, recommendations, outcomes, supervisory signature, and date in the Comments/Actions Taken/Follow-up section).

CENTRAL OFFICE REPORTING OF SUSPECTED MO HEALTHNET BENEFITS FRAUD

In the case of suspected provider or participant fraud, please provide as much information as possible, including the name of the MO HealthNet participant or provider, the date of service, and a description of the acts that you suspect involve fraud. Forward this information to the central office as above, which will then forward the complaint to:

Program Integrity Unit
PO Box 6500
Jefferson City, MO 65102-6500
Telephone: 573-751-3399

COMPLAINT, GRIEVANCE AND APPEALS DEFINED

Definitions:

Complaint:

A verbal or written expression that indicates dissatisfaction or dispute with agency policy, procedure, claims, or any aspect of agency functions.

Grievance:

A written request for further review of a complaint that remains unresolved after completion of the complaint process. The client was not satisfied with the complaint decision and has filed a written request for a grievance.

Appeal:

An appeal is a formal mechanism that allows a client the right to appeal a grievance decision. A written request for an appeal of a grievance has been filed. This action is a secondary review of an unresolved complaint.

Other:

If the report does not fall into one of the categories listed, describe the problem or concern.

NOTE: See sample of the customer complaint, grievance, and appeal policy and procedure, which can be adapted to your specific agency.

Complaint, Grievance and Appeal Letter

Sample Customer Complaint, Grievance and Appeal Letter

It is the policy of the _____ that you, as a client with this
(agency)
agency, have the right to complain, grieve or appeal if you believe your rights have been violated, to submit your concerns in writing and to be notified of the action taken or resolution of the complaint, grievance or appeal.

1. In every organization, differences may arise between people over the interpretation and implementation of policies and procedures. Prior to the decision to file a formal, written grievance, a discussion should take place with the staff member involved in the situation to attempt to resolve the conflict at the complaint level. Upon request by either the case manager or the client, the staff member's supervisor can be present for the discussion. If the situation is not resolved at this level, then a written grievance can be submitted.

2. The purpose of a grievance procedure is to provide an effective, impartial, and expedited process to resolve differences in a manner satisfactory to all parties. All written grievance documents are to be kept in a separate file for quality assurance review.

3. These are the procedures to be followed to file a grievance:

4. Describe your concern in writing and submit to the Case Management Supervisor. The supervisor will contact you within 5 working days of receipt of the grievance and set up an appointment to meet and discuss the grievance.

5. Within 5 working days of the meeting, a written explanation of the action taken or the resolution of the complaint will be sent to you.

If the resolution is not satisfactory, you may file a written appeal to the Executive Director. A response will be sent to you, as well as the staff member involved and the staff member's supervisor within 5 working days.

If you feel that your grievance has not been adequately addressed within the agency, you do have the right to file an appeal with either the district health department overseeing the program or the Missouri Department of Health and Senior Services. The phone numbers of those departments are:

_____	_____
Quality Service Manager	Director of HIV Medical Case Management
_____	573/751-6439
Telephone Number	Telephone Number

To report abuse, neglect, and exploitation you may call the DHSS, Division of Senior and Disability Services **1-800-392-0210**. You may also report online at https://health.mo.gov/safety/abuse/

To file a complaint with the State Medicaid Agency, you may call the MO HealthNet Division, Recipient Services Unit **1-800-392-2161**.

I have read and understand the above complaint, grievance and appeals policy and the procedures that must be followed for filing a grievance. I have been given a copy of these guidelines.

Signature_____ Date_____

Witness_____ Date_____