

CARE COORDINATION STANDARDS
GENERAL STANDARDS OF PRACTICE

The Division of Senior and Disabilities Services (DSDS) expects professional competency from all Care Coordinators providing waiver services to eligible Medicaid recipients. As such you will adhere to the standards set down herein:

1. The competent care coordinator will maintain a written record of all applicant/recipient contacts.

This record should include entries for the type of contact (phone, in-person, and e-mail), the date of contact, the length of contact, and complete case notes on what occurred during the contact.

The recipient must sign each record of face-to-face contact. This record will be kept within the individual recipient file maintained by the care coordinator. The care coordinator will provide copies of this documentation to the recipient and/or the recipient's legal representative(s) upon request.

2. The care coordinator will keep current, and submit all recipient documentation, on the most recent version of the DSDS forms provided on the DSDS website:

<http://www.hss.state.ak.us/dsds/> .

3. All documentation should be submitted in a timely manner, per respective regulations.

4. The care coordinator will be aware of, and avoid, conflicts of interest that would be detrimental to the recipient.

At the initial point of contact, the care coordinator will disclose any potential conflicts of interest; including their employment at an agency that may provide other services to the recipient.

5. The care coordinator will cooperate fully with the recipient's right to change care coordinators or care coordination providers at any time.

The former care coordinator must forward all documentation related to a recipient's case to the new care coordinator within ten days from the receipt of an "Authorization for Release of Information" form. The care coordinator will refrain from the solicitation of applicants/recipients who are currently receiving care coordination services from another individual or agency.

6. The care coordinator will not engage in commercial transactions with, or on the behalf of, the recipient that potentially endanger or conflict with the recipient's interests.

Care coordinators are specifically prohibited from offering, promoting, or selling health care related products and/or services (other than those offered through regular Medicaid or authorized by DSDS as part of the grant approval or certification process) to waiver recipients or their families without the written consent of DSDS and the recipient's primary care physician (within HIPAA guidelines).

7. The care coordinator will cooperate fully with all Federal, State, and Municipal oversight agencies' staff inquiries or requests related to the health, welfare, and safety of their recipient.

8. The care coordinator will, in accordance with Section 47.24.010 of the Alaska Statutes, make a report to Adult Protective Services or the Office of Children's Services whenever there is cause to believe that a vulnerable person has suffered abuse, abandonment, exploitation, neglect, or self-neglect. All reports must be made within 24 hours of discovery.
 9. The care coordinator will be familiar with regulations and standards of practice in accordance with DSDS Service Principles.
 10. The care coordinator will help the recipient manage his/her care to the maximum extent possible.
 11. The care coordinator will represent the applicant/recipient's interest with DSDS and the State.
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MEDICAID WAIVER PROCESS STANDARDS:

1. The care coordinator will make contact with the potential applicant/recipient as soon as possible upon receiving notification of referral or applicant/recipient inquiry. An informal, professional screening will be conducted to determine whether or not the applicant is appropriate for referral to the Medicaid HCB waiver program.
2. The care coordinator will provide the applicant/recipient and/or guardian with a copy of the statement of client's rights (and responsibilities), the Medicaid waiver program information, and the DSDS service principles.

The care coordinator will go over each of the items listed on this form verbally with the recipient, explaining the purpose of each right extended to the recipients and families under the Medicaid waiver program; and will ensure that the recipient understands his/her/their rights. Explain the roles and responsibilities of the care coordinator to the recipient in understandable terms and accessible formats.

3. The care coordinator will also communicate this information to the guardian, family members, and other parties involved in the planning and facilitation of services for the recipient.
4. If the applicant has not made an application for Medicaid benefits, the care coordinator will assist the applicant in completing and submitting the "Application for Medical Assistance for Adults and Children with Long Term Care Needs" form; and will assist the applicant in making/attending (will assist with the interview) his/her or their appointment with the local Division of Public Assistance (DPA) office to set an interview date.

DPA makes this appointment.

5. If the applicant has a current Division of Public Assistance DPA coupon (or upon receipt of a current DPA coupon), the care coordinator will screen the potential recipient for waiver program eligibility using the appropriate DSDS screening form. It is the responsibility of the care coordinator to assure that the applicant is appropriate for the screening process for the Medicaid waiver program.
6. The assessing agency will conduct a comprehensive assessment, within 30 days of receipt of a waiver number from DSDS, of the applicant using the DSDS "Consumer Assessment Tool" (CAT) for Older Alaskans/ Adults with Physical Disabilities (OA/APD) applicants; or by scheduling with Arbitre Inc. For Children with Complex Medical Conditions (CCMC) applicants, assessments will be done by CC. For Mentally Retarded/ Developmentally Disabled (MR/DD) applicants an ICAP will be performed.

Following the assessment procedure, obtain the required signatures and submit the assessment to DSDS. If an assessment cannot be conducted within the 30 day timeframe, please provide documentation, to DSDS, regarding the circumstances or events causing the delay(s). Care coordinators will monitor the provision of the assessment and "level of care" (LOC) determination process to ensure timely service delivery.

7. No later than 60 days after receiving notification from DSDS that the applicant meets the LOC for HCB waiver, the care coordinator will develop a plan of care and cost sheet (see Plan of Care Process and Regulations) and submit them to DSDS. Whenever this time frame is exceeded, the care coordinator will include documentation of the circumstances and/or events that are causing unavoidable delays.

PLAN OF CARE PROCESS:

(Most of these activities can be conducted while waiting for notification on whether or not an applicant meets the appropriate level of care at the CC's own financial risk)

- 7.1. The care coordinator will assist the recipient and his/her family, or circle of support, in identifying existing informal supports, and subsequent identification of necessary formal supports.

Ensure that the recipient and related individuals understand that Medicaid is the payer of last resort, and that informal and community supports should be utilized to the maximum extent appropriate prior to reliance on Medicaid.

- 7.2 The care coordinator will make contact with all informal and non-Medicaid service providers identified by the recipient.

The care coordinator will explain his/her role in coordinating services for the recipient, gather information about existing arrangements for care, and treatment plans in effect; and request prompt notification of any significant changes in service delivery to prevent duplication of services and to enhance the coordination of effort.

- 7.3 After identifying existing or available informal supports (and gathering information on the extent and nature of these services) the care coordinator will make contact with potential formal HCB waiver service providers to be included in the recipient's plan of care.

Gather information on the types of services offered, the cost of services, verify that staff meet minimum qualifications for every service, and the ability of the agency to provide the services (determine the earliest start date for each service), in order to help the recipient or family in selecting the most appropriate formal supports.

- 7.4 Fill out the plan of care and cost sheet with the recipient and/or legal representative/family member, using a person-centered planning process that places the needs of the recipient first; and respects the autonomy and self-determination of the individual who will receive services.

8. Notify the formal providers listed in the plan of care (POC) that they may begin delivering services, within two working days of receiving notification of approval of the recipient's plan of care from DSDS (plus, a determination of eligibility for Medicaid waiver services signified by the receipt of Prior Authorization numbers [PA] from DSDS). Whenever this timeframe is

exceeded, the recipient file must contain documentation of the circumstances or events causing unavoidable delays.

9. The care coordinator assumes full responsibility for the development and submission of environmental modification cost estimates to DSDS. Care coordinators are specifically prohibited from delegating the task of obtaining environmental modification cost estimates to the recipients, recipient's family, or other parties related to the recipient; by regulation.
10. The care coordinator is responsible for ensuring that no HCB waiver services varying from the approved plan of care (or in addition to), are provided until an amendment has been submitted and approved by DSDS. Payment is not guaranteed if services are rendered without amendment to the POC.
11. The care coordinator must make contact with the recipient and/or his/her legal representative *at least* twice every 30 days to: monitor the recipient's condition, the quality of service provision, and to monitor any changes in the condition (health, welfare and safety) or situation of the recipient. One of these contacts must be face-to-face with the recipient (unless exception approved by DSDS); the other contact may be over the phone or via email.
12. The care coordinator will maintain ongoing contact with family members, friends, and other informal resources that are providing assistance and support to the recipient.

This contact should be made in accordance with the recipient's consent. The *Authorization for Release of Information* form should have been filled out during the application for waiver services process.

It is the care coordinator's responsibility to ensure that the overall network of informal support provided to the recipient is well-coordinated to prohibit Medicaid expenditures for duplicate services.

13. The care coordinator should make contact with service providers included in their recipients' plans of care at least once every thirty days to confirm that services are being delivered in the amount, frequency, and duration specified in the plan of care. The care coordinator should also inquire as to whether or not a service provider has any concerns about the health and welfare of his/her recipients.
14. The care coordinator will maintain all pertinent records, and ensure documentation of all significant events and activities related to the recipient's condition and services.

These records must be kept within the individual recipient's files in accordance with the State of Alaska's policies and procedures for record-keeping; specified by the Alaska Division of Health Care Services (DHCS) in the Provider Billing manual provided by First Health Services Corporation (FHSC) to all providers upon enrollment in Medicaid.

15. The care coordinator must immediately inform DSDS via phone/email and follow up in writing whenever a recipient's social and/or health condition changes significantly. (7AAC 43.1041(f) notify DSDS within seven days of admit or discharge from hospital).

CHANGE OF CLIENT STATUS PROCESS:

- 15.1. After review of the changes in a recipient's condition, DSDS may authorize an amendment to the recipient's plan of care. Under such circumstances, DSDS may authorize the contractor to conduct an assessment from which the care coordinator must amend the plan of care; the revised plan of care should be submitted to DSDS within ten calendar days.

- 15.2. The care coordinator must inform DSDS and the appropriate service providers, in writing, of any significant event(s) that may affect the service provider (and/or DSDS operations), within five calendar days of learning of the event.

Specifically, care coordinators must provide notice regarding the following:

- 15.2.1. Death of the recipient
 - 15.2.2. Relocation of the recipient to another residence; or out-of-state
 - 15.2.3. Change of the recipient's phone number
 - 15.2.4. Change of the recipient's legal representative (e.g., guardian, power of attorney, or conservator)
 - 15.2.5. Hospitalization of the recipient
 - 15.2.6. Admission of the recipient to a nursing facility or Pioneer Home
 - 15.2.7. A transfer of care coordination (the new care coordinator is responsible for this communication)
 - 15.2.8. Denial, or loss of, the recipient's Medicaid or waiver eligibility
16. The care coordinator must secure the services of a backup care coordinator to assist, or assume, his/her duties as primary care coordinator, should he/she expect to be unreachable by phone during normal business hours for more than two consecutive days, out of the state, on vacation, incapacitated, or otherwise unable to fulfill his/her care coordination duties as required.

BACKUP CARE COORDINATION PROCESS:

- 16.1 The care coordinator must provide written documentation on the provision for backup care coordination services to the recipient; once the recipient has been approved to receive waiver services.

This documentation must include the name and contact information for the backup care coordinator and an explanation of the circumstances in which the backup care coordinator should be contacted.

It would be preferable to introduce the backup care coordinator to the recipient or family in person.

The care coordinator will also communicate this information to the guardian, family members, and other parties involved in the planning and facilitation of services for the recipient.

- 16.2 Within five calendar days of a planned absence, the primary care coordinator must provide written notification to the recipient(s) and DSDS, of the dates that he/she will be unavailable to provide primary care coordination services.

The primary care coordinator must also provide the recipient(s) and DSDS with the name and phone number of the backup care coordinator who will be covering the primary care coordinator's caseload during his/her absence.

The primary care coordinator must also provide the appropriate recipient authorizations for the release of information to the backup care coordinator within five calendar days prior to any expected absence or unavailability (*See section on Transfers of Care Coordination and Temporary Coverage*).

- 16.3 The Care Coordinator will provide access to recipient records to the back-up care coordinator during the planned absence.