

Chapter V: Implementation

5.01 Care Management / Service Coordination

A. Definition

The Community Options Program is a managed system of long term care. Care management is a required component of the program provided to all Community Options participants. Community Options care management is the comprehensive assessment of an individual's long term care needs, capacities and preferences, and the planning, authorizing, procuring, coordinating, and monitoring of appropriate services and supports to meet those needs (see Appendix I for a discussion of the essential tasks and desired outcomes of quality care management). Individual care managers need not perform all care management functions. The functional components of care management are:

1. Intake and screening;
2. Assessment;
3. Care planning and service arranging (authorization and procurement);
4. Advocating on behalf of the participant to secure the resources needed to obtain the services identified in care planning; and
5. Ongoing monitoring.

B. Required Service

Each Community Options participant shall have an assigned care manager. The participant shall be notified of the name, address and telephone number of the care manager. Designation of a care manager must be in accordance with the county Community Options Plan and required interagency agreements.

C. Care Manager Qualifications

Care management staff in Community Options must have demonstrated qualifications and abilities to determine needs and community alternatives for individuals of different age/disability groups, and knowledge of community resources that are alternatives to nursing home placement. Care management staff in Community Options must also have knowledge of the disabilities or conditions of the persons being served.

In addition, except as provided in this section, care managers, whether employed by the lead agency or serving under contracts with the lead agency, who are newly employed in or newly assigned to Community Options after December 31, 1994 shall have:

1. A BA/BS degree preferably in a health or human services related field (this does not include a registered nurse degree of less than four years),
2. Any combination of four (4) years of post-secondary education and experience, either in long term support (preferred) or other human services, may be substituted for the degree requirements with prior Department approval. Exceptions will be limited to persons adjudged to be otherwise especially well qualified to provide long term support care management, for example an individual with an AODA certification who will provide care management to AODA participants only, or a bi-lingual/bi-cultural care manager who will provide services to bi-lingual/bi-cultural participants.

D. Care Management
Supervisor
Qualifications

Care management supervisors, whether employed by the lead agency or serving under contracts with the lead agency, who are newly employed in or newly assigned to Community Options shall have:

1. A minimum of a Master's degree preferably in a health or human services related field and at least two (2) years experience in care management (care management experience in the area of long term support is preferred but not required), and successful completion of a course in supervision within the first year of hire, or
2. A minimum of a BA/BS degree preferably in a health or human services related field and at least four (4) years experience in care management (care management experience in the area of long term support is preferred but not required), and successful completion of a course in supervision within the first year of hire.

E. Training
Requirements

1. Initial Training Requirements
 - a. All care managers hired after January 1, 1995 shall attend the Long Term Care Core Course within one (1) year of hire.

- b. Currently employed care managers with less than four (4) years experience shall attend the Long Term Care Core Course no later than December 31, 1997.

2. Ongoing Training Requirements

- a. After December 31, 1994, all Community Options care managers shall receive a minimum of 30 hours every two years of ongoing training approved by the department.
- b. The lead agency, in accordance with its training plan (see Section 2.03 D 15), shall provide training opportunities to care managers in areas such as Community Options philosophy and values, program requirements, care management process and tools, interviewing skills, services for specific target populations, how to access resources, protective services, elder abuse and neglect, time management, and local policies and procedures including job expectations, record keeping and administration, and the role and function of county boards and committees.

5.02 Minimum Allowable Care Management Staff to Participant Ratio

A. Authority

The Department is required to establish standards for the minimum allowable care management staff to participant ratio (caseload size standard). §46.27 (6d)

B. Individualized Allowable Minimum Staff to Participant Ratio

The lead agency shall:

1. Complete a Community Options Annual Care Management Capacity Report (see Appendix E) each year;
2. Maintain the minimum average staff to participant ratio standard established for the agency through the Care Management Caseload Size Worksheet process;
3. Develop and implement a plan to achieve the standard if it is not currently within the allowable tolerance limits (see Section 5.02 D) and has not been granted a variance (see Section 5.02F).

Note: A county already meeting the standard in 1995 is expected to maintain compliance. A county not in compliance is expected to reach the standard during 1995. The Department will work with those counties not in compliance to develop a plan to reach the standard by the end of 1995.

- C. Department Fiscal Responsibility The Department will take all reasonable steps to assure that sufficient funding is available to lead agencies to meet the added cost of complying with new caseload size standards. The Department shall grant an agency's request for a variance, as described below, if the Department has been unable to provide such funding availability.
- D. Tolerance Limits The Department shall annually establish tolerance limits within which a lead agency's actual staff to participant ratio may range without requiring the withholding or earmarking of newly allocated funds, closing of intake, or similar remedial action. The purpose of the tolerance limit is to allow time to phase in the standard and to account for random fluctuation in either caseload or staff turnover. (Example: Assume a county's minimum staff to participant ratio is 1:32. At a tolerance limit of 125%, the lead agency's actual staff to participant ratio could range up to 1:40 - 125% of 1:32 - before remedial action is required by the Department.) Tolerance limits are identified each year in Appendix C and will not be lower than 110% in any year.
- E. Administrative and Fiscal Remedies For each individual county, the Bureau of Long Term Support will make a determination, based upon the Care Management Caseload Size Worksheet, whether the lead agency is below its minimum staff to participant ratio.
- A lead agency that is below its minimum staff to participant ratio must submit a plan for increasing COP, COP-W and CIP II care management staff in order to reduce the average caseload size.
- In addition, a lead agency that is below the tolerance limit for its minimum staff to participant ratio, is not granted a variance (see Section 5.02 F), and does not have an approved plan for achieving compliance with the standard may have any new service allocations withheld and redistributed to other lead agencies on a permanent basis until such time as a plan of correction is approved or its average caseload size is within the tolerance limit.
- F. Variances to the Standard Variances to the standard for a lead agency that is below the tolerance limit for its minimum staff to participant ratio may be granted if the agency agrees to take necessary remedial action before serving any new participants, takes all reasonable steps to access available state or federal funds, and demonstrates one of the following:
1. Emergency or clearly unusual circumstances;

2. Added costs due to new staffing quality standards which are not met by commensurate increases in the county's allocation. Prior to beginning the calendar year the agency must demonstrate that
 - a. the cost of inflation for services to current participants, plus
 - b. the added cost of increased services for current participants which the agency will provide, plus
 - c. the added cost of meeting new tolerance limits will exceed the county's allocation for the succeeding calendar year.

5.03 Intake and Referral

- A. Definition
Intake and referral is the process of receiving and responding to requests for assistance, gathering basic identifying information about the person and his/her needs, making a preliminary determination of eligibility, determining whether the applicant should receive an assessment, and providing information and referrals to other possible sources of assistance as appropriate.
- B. Application
The lead agency's intake system is required to document the date each individual applies for long term care. The lead agency must use some form of written application for any person who requests to file a written application for Community Options.
- C. Referral
Anyone may make a referral to the Community Options program. Those who make multiple referrals (such as agencies and hospitals) shall be given information by the county lead agency to help them make appropriate referrals.
- D. Procedures
County procedures shall include a description of the Community Options program and other long-term support services, specific services provided, eligibility criteria for Community Options assessments, plans and services, and a description of how referrals are made to the Community Options program.
- E. Intake
Responsibility
The lead agency shall specify agencies/staff persons who shall be responsible for intake. Those agencies/staff persons have the following responsibilities:
 1. Take referrals and applications for the Community Options program;

2. Inform applicants of their rights and responsibilities, including information about cost-sharing and estate recovery obligations (see Sections 2.05 and 2.06);
3. Arrange for an initial contact with assessment staff, consistent with the urgency of the situation.

5.04 Decision to Proceed With Assessment

A. Denial of an
Assessment

Eligibility requirements for an assessment are explained in Section 4.02. A county is not required to provide an assessment to any person:

1. Not expected to be medically indigent within 6 months in a nursing home (private pay) seeking admission to or about to be admitted to a nursing home who is informed about the Community Options program but who waives the assessment (§46.27(6)(a)2.b.);
2. Seeking admission to or about to be admitted to the Wisconsin veterans home at King who is informed about Community Options but who waives the assessment;
3. Excluded because of gradual implementation of the program, as specified in the county's Community Options Plan;
4. Considered an emergency admission to a nursing home, as determined by a physician, but an assessment shall be done within ten (10) days of admission;
5. Readmitted to a nursing home from a hospital within six (6) months after being assessed;
6. Entering a nursing home for "recuperative care" (see Appendix F);
7. Entering a nursing home for respite care;
8. Admitted to a nursing home from another nursing home, unless the person requests an assessment;
9. Paying privately for services who does not want to be assessed or, if the county has established a policy of charging a fee for assessments, who refuses to pay the fee for the assessment;

10. Refusing to release the information needed to conduct the assessment;
11. Not meeting program eligibility if the county, with approval of the Interagency Long-Term Support Planning Committee, has chosen to apply the Community Options Functional Screen prior to assessment;
12. Not otherwise excluded, but for whom the funds needed to conduct an assessment are not available because the county has expended all funds available for conducting assessments.

B. Notification

Notification is the process of letting applicants and program participants know about any changes in their status or in the services they receive in a format that is understandable and accessible to them. Except in "emergency situations" (see Appendix F), the lead agency shall provide notification to the Community Options applicant within thirty (30) calendar days from the date of application regarding:

1. Approval for an assessment and when the assessment will be conducted (notice of approval for an assessment may be written or verbal); or,
2. Denial of an assessment and the reason why (notification of denial of an assessment must be in writing and include information on appeal and grievance rights).

C. Waiting List

A county must provide an opportunity to be placed on a waiting list for any applicant who is denied an assessment because the county has expended all funds available for assessments.

5.05 Assessment

A. Definition

Assessment is a structured process of interviews which is used to identify the participant's abilities, needs, preferences and supports; determine eligibility for programs and services; and provide a sound basis for developing the care plan. A secondary purpose of the assessment is to provide the participant with a good understanding of the program and the services that can be provided and of what is expected of him/her. Assessments are conducted in partnership with the participant and his/her family, guardian, or other supports as appropriate.

- B. Responsibility The lead agency shall ensure that the offer of an assessment is standard throughout all referral and assessment agencies in the county. An offer shall include an explanation of: the purpose of a Community Options assessment, the applicant's right to choose whether or not to be assessed (including whether or not the applicant may be responsible for cost-sharing for the assessment), the right to have other persons involved in the assessment process, and the applicant's right to decide after the assessment and care plan are completed whether to accept offered community-based services.
- C. Accommodating Disabilities The assessment shall be offered and developed in a manner that provides participants with impaired mental, physical or sensory functioning an equal opportunity to participate in and benefit from the assessment. Communication aids such as taped or Braille material, or interpreters for persons with hearing impairments shall be provided at no cost to the participant.
- D. Timeline An applicant who is not denied an assessment has the right to receive a Community Options assessment within forty-five (45) calendar days of application. The lead agency may delay an assessment for an applicant who is eligible but will be placed on waiting list for services provided that the applicant:
1. Has been informed of her/his right to an assessment within the 45 day time limit, and
 2. Has been informed of the potential benefits the assessment may have even if service funds are currently unavailable, and
 3. Voluntarily agrees to delay the assessment based on an informed choice, and
 4. Is placed on the waiting list for services.
- E. Emergency Situations In emergency situations an applicant must receive a direct contact (phone or face-to-face) by referral or assessment staff within 72 hours of application or referral, and an assessment (unless delayed as per Section 5.05 D) must be conducted within ten (10) days of any emergency nursing home admission (§46.27(6)(a)2.b.). "Emergency situations" are defined in Appendix F. With approval of the Long-Term Support Planning Committee a county may define additional situations it will consider to be emergencies.

- F. Procedures
- Each assessment shall be completed in accordance with county assessment procedures and requirements of §46.27(5) and (6). The department shall approve county assessment procedures as part of the county Community Options Plan. County assessment procedures shall include a process that will:
1. Discover what the applicant's lifestyle and service arrangement preferences are.
 2. Identify the supports possible and different options for meeting the applicant's needs no matter how intense those needs are. This includes informal support systems, formal community resources and yet to be developed resources.
 3. Identify and make appropriate referrals to other programs and funding sources for which the applicant may be eligible.
 4. Explain the assessment and care planning process to the participant, including:
 - a. The fact that the services the participant receives will depend on the needs identified in the assessment;
 - b. An acknowledgment of the intrusiveness of the assessment process and an explanation of the kinds of questions which will be asked and why; and,
 - c. An explanation of confidentiality procedures and who will have access to information collected.
- G. Assessment Activities for Medicaid Community Waiver Participants
- Current needs assessment information is required as part of a service plan packet for participants in the Medicaid community waivers. To be "current" such information must have been obtained within three months of the start date for waiver-funded services. Community Options may pay for such assessment activities. However, it is important that these activities be billed correctly (see Section 7.05 F for correct billing procedures).

- H. Staff
Assessment staff used by Community Options must have demonstrated qualifications and skills in determining both medical and social needs of persons who are assessed, abilities to determine needs and community alternatives for individuals who are of different age/disability groups, and knowledge of community resources that are alternatives to nursing home placement. Assessment staff used by Community Options must also have knowledge of the disabilities/conditions of the persons being assessed. A multi-disciplinary assessment team composed of, at minimum, a nurse and a social services worker is a recommended approach to meeting this requirement. The department recommends that wherever possible, counties use public health nurses who meet the requirements of §141.045(1) as members of assessment teams.
- I. Face-to-Face Contact
An assessment, at a minimum, shall include a face-to-face discussion with the Community Options applicant and his or her guardian, if any.
- J. Involvement of Others
Unless permission is denied by the applicant or guardian, the assessment shall include direct contact with persons in the community who are directly acquainted with the Community Options applicant, such as family members, friends, health care providers, and neighbors. The assessment shall include direct contact and facilitate coordination with community agencies (Independent Living Centers, social, mental health, developmental disabilities, chemical dependence agencies) that have statutory responsibilities and expertise to serve the Community Options applicant.
- K. Content
The minimal contents of an assessment must be outlined in the county Community Options Plan and shall include discovery and documentation of the applicant's needs and abilities in at least the following areas:
1. Physical health (including medical restorative or (re)habilitative care);
 2. Physical activities of daily living;
 3. Instrumental activities of daily living (e.g., laundry, cooking cleaning);
 4. Communication;
 5. Emotional functioning;
 6. Mental health/cognitive functioning;

7. Social participation and functioning, including consideration of age and culturally appropriate behaviors;
8. Educational/vocational activities;
9. Informal support systems;
10. Physical environment;
11. Economic resources;
12. Capacity for self-care, including the use of adaptive equipment or training;
13. Personal preferences.

L. Outcome

In addition, the assessors must look at the extent to which the potential community resources would facilitate the following basic and desirable accomplishments:

1. Personal safety;
2. Maintenance of health;
3. Individuality, autonomy and self-determination;
4. Protection of rights;
5. Personal continuity, continuous growth and learning;
6. Maximum community participation and social growth.

M. Documentation

All assessments shall result in a written document that specifies what would be necessary for the applicant to live in the community arrangement of his or her choice, and what supports and service arrangements would be necessary to achieve the goals of normalization. A copy of the assessment shall be given to the applicant, if requested.

5.06 Decision to Develop a Care Plan

A. Denial of a Care Plan

Eligibility requirements for care plans are explained in Section 4.03. Upon completion of the assessment, a decision must be made whether a care plan will be developed for the participant. A county is not required to provide a care plan to:

1. Any person who does not want to proceed with development of a care plan or, if the county has established a policy of charging a fee for care plans, who refuses to pay the fee for the care plan;
2. Any person who refuses to release the information necessary to develop the care plan;
3. Any person who does not meet program eligibility if the county has chosen to apply the Community Options Functional Screen prior to care plan development;
4. Any person for whom the county has determined, through the assessment, that services in the community are not feasible or financially viable (see Section 5.06 B and C); or,
5. Any person not otherwise excluded, but for whom the funds needed to develop a care plan are not available because the county has expended all funds available care plans.

B. Feasibility

Services in the community are feasible unless, based on information obtained and documented through the assessment, the county determines that the health, welfare or safety of the individual and/or others cannot reasonably be assured.

C. Financial Viability

Services in the community are financially viable unless the county determines that the cost of meeting community service needs identified in the assessment will:

1. Exceed the average monthly Medicaid payment for nursing home care as specified by the department in Appendix C, unless an exemption is granted under Section 5.09 B;
2. Cause the county to exceed the allowable average Community Options service cost for all county Community Options participants, and the department has denied a variance to the allowable average service cost; or
3. Exceed the state and federal service funds available (service funds are available if they are not already committed to current participants or earmarked for members of a target group to which the applicant does not belong).

- D. Notification
- Notification is the process of letting applicants and program participants know about any changes in their status or in the services they receive in a format that is understandable and accessible to them. The lead agency shall notify a Community Options participant within thirty (30) calendar days of the date of completion of the assessment regarding:
1. Approval for development of a care plan and when the care plan will be developed (notice of approval for a care plan may be written or verbal); or,
 2. Denial of care plan development and the reason why (notification of denial of a care plan must be in writing and include information on appeal and grievance rights).
- E. Waiting List
- A county must provide an opportunity to be placed on a waiting list for any applicant or participant who is denied a care plan because the county has expended all funds available for developing care plans, or for whom the county has determined services in the community not financially viable.

5.07 Care Plan Development

- A. Definition
- Care planning is the process of identifying, authorizing, and procuring services to meet the participant's needs and preferences as identified in the assessment. Care planning involves working in cooperation with the consumer and his/her family, guardian or other supports as appropriate. The result is a written document or care plan which is consistent with consumer preferences and professional judgment. The care plan includes documentation of resource availability by addressing efforts to include informal supports, Medicaid card and waiver services, and community resources in addition to COP funded services.
- B. Responsibility
- In offering to develop a care plan, a lead agency shall:
1. Include an explanation of the purpose of the plan, whether there will be a fee for the plan, the right to have other persons involved, and after completion of the plan the right to decide whether to accept offered community-based services.
 2. Assure that the applicant/participant (or guardian, if any) is actively involved in the development of the care plan.
 3. Designate agencies/staff persons responsible for care plan development, and seek to involve community agencies that have statutory responsibility for serving particular age/disability groups in the process of the development of the plan.

- C. Accommodating Disabilities The care plan shall be offered and developed in a manner that provides participants with impaired mental, physical or sensory functioning an equal opportunity to participate in and benefit from the development of the care plan. Communication aids such as taped or Braille material, or interpreters for persons with hearing impairments shall be provided at no cost.
- D. Timeline Each care plan shall be developed within a reasonable time as specified in the county's Community Options Plan.
- E. Emergency Situations In "emergency situations" (see Appendix F), a lead agency may initiate services prior to completion of a care plan. In such situations, a direct contact with the applicant must have been made, an assessment initiated (see Section 5.05 E), and the care plan must be completed within thirty (30) calendar days of the beginning of services.
- F. Procedures Each care plan shall be developed in accordance with lead agency care plan procedures and these Guidelines in order to meet the unique needs of the participant as identified in the assessment. As part of the care planning process the lead agency shall:
1. Provide the participant and others participating in care plan with appropriate information about the services potentially available to meet the needs identified in the assessment; and,
 2. To the maximum extent practicable, honor the lifestyle choices and preferences of the applicant which are necessary, safe, realistically available or could be developed, and consistent with the purpose of the program; and,
 3. Ensure that the care planning process results in a written document that can be used by the participant in understanding:
 - a. The total package of services delivered through Community Options and other sources; and,
 - b. The role of the care manager in securing, organizing and monitoring services; and,

- c. The participant's own role in monitoring services and providing feedback to the care manager on the quality and effectiveness of services in meeting needs; and,
- d. The role of the provider agency(ies) and staff in the ongoing monitoring of participant functioning and wellbeing and the suitability services; and,
- e. The efforts made to secure other funding sources such as Medicaid, informal supports and other available resources in the community.

G. Content

Each care plan must be in written form and include, at a minimum:

1. A description of the types of services identified in the assessment as needed to maintain the applicant in the community, including a description of the types of services and service providers preferred by the applicant, and if applicable, a statement of the reason(s) the lead agency decided not to honor the applicant's preferences for services or service providers;
2. A comprehensive inventory which covers all supports (formal and informal) and services which are part of the care plan;
3. A description of who will provide each medical or social service, whether or not each service is a paid service, the location of each provided service, how much is required of each service on a daily, weekly or monthly basis, and the most cost-effective funding source and amount for each service (except for the amounts for Medicaid or Medicare, if unknown);
4. The beginning and ending dates of service delivery, including dates for formal periodic reviews;
5. A description of family and other informal support services (whether paid or unpaid) provided to the applicant, including the extent to which assistance is needed to preserve informal support involvement;
6. The designation of the care manager and his/her specific responsibilities, the frequency of contacts determined to be needed (see also Section 5.11 C), and the name and telephone number of the care manager and his/her alternate should he/she be unavailable;

7. A description, based on the comprehensive assessment, of the means by which the care plan will be monitored over time to assure the objectives of the care plan are being met;
8. Identification of the roles of the care manager, provider agency(ies) and participant in directing and supervising direct care workers;
9. Written information for the participant about who to contact in case of an emergency, including after hours, weekends and holidays;
10. A description of the way in which the participant can initiate changes in the care plan;
11. Notation of any service(s) identified as needed that will not be provided and why, including refusal by the applicant/participant to accept the service; and,
12. Documentation that significant personal risks in the individual's care plan of which the lead agency is aware have been discussed with the participant by the care manager. An agreement shall be negotiated between the participant and the care manager describing the perceived risks and what to do should the safety of the participant be threatened further.

H. Participant Review
and Approval

There shall be documentation in the participant's file that the participant (and guardian, if any) has reviewed the care plan. This documentation should be through the participant's (or guardian's) signature on the care plan. A copy of the care plan shall be given to the applicant/participant (or guardian).

5.08 Decision to Proceed With Ongoing Services

A. Denial of Ongoing
Services

Eligibility requirements for Community Options-funded services are explained in Section 4.04. Upon completion of a care plan, a decision must be made whether services will be offered to each participant.

A county shall not provide Community Options-funded services to any person:

1. Who does not meet program eligibility requirements;
2. Who does not meet financial eligibility requirements;

3. Who does not meet the residency requirement for receipt of Community Options-funded services (see Section 4.04 C);
4. For whom the county has determined, through the assessment and care plan, that services in the community are not feasible or financially viable (see Sections 5.06 B and C);
5. Refuses to release or provide the medical, income, asset (including signing an Estate Recovery Disclosure Form), or other information necessary to determine program or financial eligibility or cost-sharing obligation; or,
6. Initially receives services on or after January 1, 1990, is eligible for and has been offered available services funded through a Medicaid community waiver but who has refused such services.

A county is not required to provide Community Options-funded services to any person:

1. Who does not want to receive services;
2. Who is a member of a target group for which the county has established a waiting list for purposes of meeting minimum significant proportions requirements for other target groups.

B. Cost-Sharing

A participant may be required to share in the cost of fee chargeable services (see Section 2.05 A). The amount of cost-sharing that will be the participant's responsibility is determined prior to, and presented as part of, an offer of services.

C. Estate Recovery Information

The lead agency is required to do all of the following:

1. Complete an Estate Recovery Program Disclosure Form for each participant who is age 55 or older (see Section 2.06).
2. Inform participants at intake, prior to placement on a waiting list, and at the time that services are offered of the circumstances under which the department may recover the cost of any services provided from his/her estate.

- D. Private Pay
- A participant denied services due to financial ineligibility must be informed of the potential for obtaining services by paying privately for any or all of the services (including care management) identified in the care plan. Persons paying privately are responsible for 100% of the cost of services. §46.27(5)(d)2.
- If any long-term support services, including ongoing care management are provided directly by a county agency, then those services must be provided on a fee-for-service basis to private pay individuals if the county agency has the capacity to do so. If the county anticipates lacking the capacity to serve private pay individuals, then it must establish, with the approval of the Interagency Long-Term Support Planning Committee, the maximum capacity it has to provide services (i.e., establish a maximum caseload size for care managers).
- E. Notification
- Notification is the process of letting applicants and program participants know about any changes in their status or in the services they receive in a format that is understandable and accessible to them. The lead agency shall provide notification to Community Options participants within thirty (30) calendar days of the date of completion of the care plan regarding:
1. Approval for services and when they will begin (notice of service approval may be written or verbal); or,
 2. Denial of services and the reason why (service denial notification must be in writing and include information on appeal and grievance rights).
- F. Waiting List
- A county must provide an opportunity to be placed on a waiting list for any participant who is denied Community Options-funded services because:
1. The county has expended all service funds or reasonably projects that all service funds are committed to current Community Options participants; or,
 2. The person is a member of a target group for which the county has established a waiting list for purposes of meeting significant proportions requirements for other target groups.
- G. Waiting List Procedures
- The following are the minimum procedures which must be met by counties in placing applicants on service waiting lists:
1. Make an offer of an assessment;
 2. If the offer of an assessment is accepted the assessment must be completed before the applicant is placed on the waiting list;
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3. If the offer of an assessment is not accepted the following procedures must be completed prior to placing the applicant on the waiting list:
 - a. A determination of eligibility for the applicant using the Community Options Functional Screen; and,
 - b. Documentation that the county has made an initial determination that the applicant is financially eligible for Community Options- or Medicaid community waiver-funded services; and,
 - c. Documentation that the applicant has received a personal contact by agency staff and has current service needs; and,
 - d. Documentation, based on the applicant's declaration of state residency, that on the date of placement on the waiting list the applicant meets the Community Options residency requirement (See Section 4.04 C).

5.09 Service Delivery

A. Responsibility

The lead agency shall, within the limits of state and federal funding, provide feasible and financially viable Community Options-funded long-term community support services to implement the care plan of any applicant or participant who is eligible for receipt of such services and who meets Community Options residency requirements (See Section 4.04 C). Long-Term community support services are those goods or services identified in the care plan as necessary to allow an individual with long-term care needs to remain in or return to the community.

The lead agency shall monitor the use of Community Options service funds to confirm that expenditures are reasonable and consistent with the guidelines concerning limitations on the use of COP funds, as articulated in Chapter 2. With the approval of the Interagency Long Term Support Planning Committee, a county may establish a written policy to promote additional monitoring of unusual expenditures.

B. Emergency Situations

In "emergency situations" (see Appendix F), a county may initiate services prior to completion of a care plan provided that:

1. There has been a direct contact with the applicant;
2. An assessment has been initiated (see Section 5.05 E);

3. A care plan is completed no later than thirty (30) calendar days, following initiation of services (see Section 5.07 E); and,
4. Community Options funds may be used to pay for emergency services retroactively to the date the assessment was initiated but under no circumstances more than thirty (30) calendar days prior to completion of the care plan.

C. Flexibility of
Community
Options-Funded
Services

Community Options funds may be used flexibly, within the limits specified in Section 2.04, to implement the care plan. Community Options-funded services may be provided only in accordance with a care plan. In emergency situations (see Sections 5.05 E, 5.07 E and 5.10 B), Community Options-funded services may be initiated prior to development of a care plan.

Community Options may be used to pay for any traditional or nontraditional services, such as room and board and medical expenses.

There are no department limits to the use of family members as paid service providers, or cash payments to participants to purchase services (such payments are subject to the requirements of HSS 73, see Appendix H). However, with approval of the Interagency Long-Term Support Planning Committee a county may establish such limits by written policy in the county Community Options Plan.

Community Options-funded services include services funded either through regular Community Options program or the Community Options-Waiver. Substitution of one funding source for another does not, in itself, constitute reduction or termination of services.

D. Supportive Home
Care Provider
Agreements

Negotiated provider agreements must be provided in accordance with Chapter HSS 73.06 (see Appendix H) within two weeks of initiation of supportive home care services, unless the lead agency expects services to be provided for less than 30 days.

E. Reduction of
Services

Community Options-funded services may be reduced only in the following situations:

1. In accordance with changes in the level of need identified in an updated care plan; or,

2. The county allocation is insufficient to meet the service commitment to current participants, and the county has:
 - a. Made all reasonable efforts to secure resources to avoid service reductions;
 - b. Closed admission to new participants;
 - c. Assured that the reduction in services does not endanger the health and safety of the participant and/or caregivers, and has referred the participant to other available programs and services needed to protect the health and safety of the participant; and,
 - d. Adopted a fair and equitable policy for distributing service reductions among participants.

F. Termination of Services

Community Options-funded services may be terminated only in the following situations:

1. The participant is no longer eligible for Community Options services; or,
2. The participant no longer needs Community Options services; or,
3. The health, welfare and safety of the participant or others can no longer be reasonably assured; or,
4. The participant has fraudulently obtained or misused Community Options funds or Community Options-funded services; or,
5. A participant who initially received services on or after January 1, 1990 has become waiver-eligible but has refused Medicaid community waiver services (see Section 2.04 L); or
6. The county allocation is insufficient to meet the service commitment to current participants, and the county has:
 - a. Made all reasonable efforts to secure resources to avoid service reductions;
 - b. Closed admission to new participants;

- c. Assured that the reduction in services does not endanger the health and safety of the participant and/or caregivers, and has referred the participant to other available programs and services needed to protect the health and safety of the participant; and,
- d. Adopted a fair and equitable policy for distributing service reductions among participants.

G. Notification of Reduction or Termination of Services

Notification is the process of letting applicants and program participants know about any changes in their status or in the services they receive in a format that is understandable and accessible to them. The lead agency must provide notification to participants of any reduction or termination of services not initiated or agreed to by the participant. The lead agency shall mail a notification of reduction or termination of services to the participant or guardian at least ten (10) working days prior to the effective date of any reduction or termination of services. The required notification shall inform the participant or guardian of, and provide an opportunity to file, a state appeal and/or county grievance.

The participant must be given timely advance notice, verbally or in writing, of any other changes in the care plan. The participant and the participant's service providers shall be provided ten (10) days advance notice of a permanent change of care manager. Temporary substitutions due to illness, vacation, etc., do not require notice. Notice includes information about the right to file a county grievance.

5.10 Ongoing Monitoring of Service Delivery

A. Definition

Ongoing monitoring is the process of verifying that services are being provided as called for in the care plan, determining whether the care plan and services provided continue to be appropriate to meet the participant's needs, and making adjustments to the care plan and service arrangements when necessary. Monitoring involves periodic contact with the participant, caregivers, service providers and others who play a significant role in the participant's life and the success of the plan. Regular contact is vital to the continuity of service and to maintaining a friendly, trusting relationship in which needs, preferences and concerns can be openly identified and discussed.

- B. Monitoring Responsibilities
- The care manager is responsible for assuring that the care plan Responsibilities objectives are met. The care manager must determine when changes in the care plan are needed, initiate any reassessments, and seek necessary consultation.
- C. Frequency of Contact
- After June 30, 1994, the care manager shall have regular contact with each participant and with the participant's service providers as specified in the care plan. Minimum contact requirements are as follows:
1. **Initial Monitoring Contacts.** Initial Monitoring contacts are those which occur within the first thirty (30) days of the beginning of Community Options-funded services. At a minimum, care managers must have contact (face-to-face or telephone) with the participant and with a provider agency, caregiver or some other person who is significant in the care plan within the first thirty (30) days of the beginning of Community Options-funded services. No exceptions are allowed.
 2. **Ongoing Monitoring Contacts.** Ongoing monitoring contacts are those which occur following the first thirty (30) days of the beginning of Community Options-funded services.
 - a. Determining type and frequency of ongoing monitoring contacts is done jointly by the participant (or guardian) and care manager and is documented in case notes and in the six month review and update of the care plan. This determination is based on the following variables:
 - 1) Stability or frailty of the participant's health;
 - 2) Ability of the participant to direct her/his own care;
 - 3) Strength of in-home supports and the participant's informal support network;
 - 4) Stability of in-home care staff (e.g., historical frequency of turnover, availability of emergency back-up);
 - 5) Stability of the participant's care plan (e.g., historical and/or anticipated frequency of changes or adjustments to the plan).

It is anticipated that some participants will require more contact than the minimum required frequency of contacts.

- b. The minimum required frequency of ongoing monitoring contacts are:
 - 1) A face-to-face or telephone contact with the participant, or a face-to-face, written or telephone communication with a collateral contact (provider agency, caregiver, family member or some other person who is significant in the care plan) is required at least once each month. (Recommended best practice is for both participant and collateral contacts monthly.)
 - 2) A face-to-face contact with the participant is required every three (3) months.
- c. Exceptions to the frequency of ongoing monitoring contacts may be made after the first six months of a participant's initial care plan (or sooner if the participant is already known to, or has received services in the past from, the care manager or lead agency).

Exceptions to the minimum frequency of ongoing monitoring contacts may be made only if:

- 1) Requested by a participant who resides in her/his own home or apartment; and,
- 2) Agreed to by the care manager and approved by the care management supervisor.

The variables used in determining the type and frequency of ongoing monitoring contacts (see Section 5.11 C 2 a) are also used to determine the appropriateness of an exception. Such exceptions are obtained by documenting in the participant's file that less frequent contacts were requested by the participant, the participant resides in his/her own home or apartment, and the exception is agreed to by the care manager, and approved by the care management supervisor.

- 3. **Six Month Care Plan Review.** A face-to-face contact with the participant to review and update the care plan is required every six (6) months. The participant or guardian has the right to decide whether service providers, family, and anyone else may be part of the meeting. No exceptions are allowed.

5.11 Variances to Service Limitations and Funding Limitations

A. County Approved Variances

The Interagency Long-Term Support Planning Committee may approve variances to service limits in two situations noted below. A subcommittee or an individual committee member may be designated to approve or deny variances as long as the full committee periodically reviews these actions.

1. **New Community Options Participants Residing in a Nursing Home.** A variance may be granted to allow the use of Community Options funds to provide community-based services for specific new participants currently residing in an institution if the Community Options-funded services are provided in accordance with a discharge plan. The intention of this variance is to allow for the initiation of a living arrangement and/or development of a community support network prior to discharge. This variance may be granted up to 90 days prior to discharge, is not renewable, and is limited to one variance per participant in any calendar year.
2. **Current Community Options Participants Receiving Services Provided During a Recuperative Stay in an Institution.** A variance may be granted to allow the use of Community Options funds to continue to pay for non-institutional community service expenses for up to 90 days for each separate institutional admission of a current Community Options recipient. The intention of this variance is to maintain a participant's support network during relatively brief institutional stays. As stated in Section 2.04, no variance is needed for recuperative stays of 30 days or less.

B. State Approved Variances

The department may approve a variance to service limitations or for funding limitations in four situations:

1. **Current Community Options Participants Residing in the Community Receiving Adult Day Care or Other Services Provided in an Institution.** If requested by the Interagency Long-Term Support Planning Committee, the department may, on a case by case basis, grant a variance to allow Community Options funds to pay for some services including adult day care, day services, prevocational services, daily living skills training and/or respite (except for overnight stays in a nursing home) provided in an "institution" (see Appendix F).

2. **Community Options Participants Residing in a CBRF Larger Than 8 Beds.** If a person initially received COP funds while residing in a CBRF prior to January 1, 1996, no variance is required to continue to use Community Options funds for that person in that specific facility (see Section 2.04 M). If a variance was required for the person to reside in the facility prior to January 1, 1996, the lead agency shall maintain a copy of the variance that was in effect on December 31, 1995 in the participant's case record. (These persons are grandfathered in regardless of whether a variance may have been required in the past.)

Note: See Community Options Information Bulletin #87 for a description of the process by which such CBRF's are certified as consisting entirely of independent apartments.

A variance is required to use Community Options funds for a participant who, on or after January 1, 1996, enters a CBRF licensed for more than eight (8) beds. Except that no variance is required for an elderly participant who will reside in a facility certified by DCS as consisting entirely of "independent apartments" (see Appendix Z), occupied by not more than two unrelated individuals.

A variance may be granted for a participant to reside in any size facility if the facility was licensed prior to July 29, 1995. No variance may be granted for a participant to reside in a facility licensed on or after July 29, 1995 for more than 20 beds.

A lead agency is not required to apply or reapply for a variance nor to contract for services in a CBRF for which a variance is required. Lead agencies may limit the circumstances under which they will seek a variance to the CBRF size limit (e.g., for participants with Alzheimer's disease).

The Department shall approve a request for variance if, based on the required documentation (see below) submitted by the lead agency, it finds that the proposed living arrangement meets all of the following criteria:

- a. The placement is the preferred residence of the participant and/or their guardian;
- b. The facility provides a quality program and living environment;

- c. The placement is cost effective as compared to other, less restrictive, residential arrangements;
- d. For a participant with Alzheimer's disease or a related dementia, the facility demonstrates a capability to meet the special needs of the participant.

The required documentation for a request for a variance to the CBRF 8 bed size limit includes all of the following:

- a. A copy of the participant's Functional Screen.
- b. A copy of the participant's care plan from the facility, showing the facility rate and the services that will be provided by the CBRF, including any special accommodations or arrangements that the facility will be providing to meet the participant's special needs.
- c. A general description of the CBRF where the person will reside including: a) the CBRF's name and address, licensed capacity and class; b) a copy of the CBRF's program statement/description; c) a copy of the latest CBRF survey findings for the facility; d) a description of the CBRF's efforts to provide services in a manner that enhances resident dignity, independence, privacy, choice and decision making regarding operations of the facility, and that mitigate the negative effect of large, congregate living environments.
- d. If the variance is requested for a participant who has Alzheimer Disease, or a similar form of dementia, documentation provided by the CBRF that it can accommodate the special needs of the participant through: a) the facility environment, b) special programmatic features, and c) specific staffing and staff training to deal with persons with dementia.
- e. A cost comparison showing that the cost of care for the participant in this CBRF is less than the estimated cost of serving this participant in a less restrictive residential setting such as an individual apartment or Adult Family Home.

3. **County Exceeding Allowable Average Community Options Service Cost.** The department may approve a variance to the limitation that prohibits a county Community Options program from averaging more in expenditures per Community Options participant than the state would expect to pay under the Medicaid program if those participants were residents of nursing homes.
4. **Limit to Administrative Expenses.** The department may grant a temporary variance to the seven (7) percent limitation on the use of Community Options service funds to pay unusual administrative costs. "Unusual" costs may be one-time administrative costs, or may be ongoing administrative costs provided there is a county plan to reduce reliance on variance funds. Such variances may be granted provided that the increased administrative funds are used to:
 - a. Improve implementation and management of the Community Options Program or Community Options-Waiver;
 - b. Implement a county-administered Medicaid-funded personal care program;
 - c. Develop the curriculum and defray extra administrative costs for the initial implementation of a program of ongoing training for agency staff who are responsible for the performance of duties in the Community Options Program.

C. Variance Process

Lead agencies are not required to seek any variance defined in this Section except when an individual will be denied services as a result of the lead agency exceeding the allowable average Community Options service cost (see Sections 2.04 E and 5.12 B 3). To seek approval of a variance to service limitations or funding limitations, the following process must be followed:

1. All variances are specific to individual recipients and not to any particular service or service provider.
2. Variances may be subject to time limitations or other conditions.
3. A copy of any variance approval must be maintained in the participant's file.

4. County Approved Variances are obtained in the following manner:
 - a. Requests for county approved variance must be submitted to the county's Interagency Long-Term Support Planning Committee (or designated committee member(s) with full committee approval after the fact) for approval or denial.
 - b. A summary of county approved variances shall be reviewed annually by the Interagency Long-Term Support Planning Committee.
5. State Approved Variances are obtained in the following manner:
 - a. State approved variance requests must be submitted to the county's Interagency Long-Term Support Planning Committee (or designated committee member(s) with full committee approval after the fact) for approval or denial.
 - b. Request for variances for current Community Options participants residing in the community receiving adult day care or other services provided in an institution, or for Community Options participants residing in a CBRF larger than 8 beds must be:
 - 1) Submitted to the DCS Area Administrator for approval in a timely manner. Except in "emergency situations" (see Appendix F), approval by the DCS Area Administrator is required prior to initiating services which require a state approved variance. In emergency situations, services may be initiated provided a written request for approval of a variance is submitted within five (5) working days of initiation of services.
 - 2) Within 10 working days the DCS Area Administrator shall, in writing, either approve, approve conditionally, or disapprove the state approved variance request.
 - c. Request for variances to the county exceeding the allowable average community options service cost, or the limit on administrative expenses must be submitted to the Bureau of Long Term Support. The Bureau of Long Term Support shall, in writing, either approve, approve conditionally, or disapprove the state approved variance request.

- d. A summary of state approved variances shall be reviewed annually by the Interagency Long-Term Support Planning Committee and the department.
6. The Interagency Long-Term Support Planning Committee has two distinct responsibilities in reviewing variances requested by the lead agency:
 - a. To review and approve or deny each initial request for a variance. This review is intended to insure that services to a participant are provided in the most appropriate manner and the least restrictive setting available to meet the participant's needs. Approval/denial is based upon the participants needs, the availability of services to meet those needs, and upon a demonstrated lack of other more appropriate service types or locations.
 - b. To annually review all variances to insure that services to participants continue to be provided in the most appropriate manner and least restrictive setting available to meet the participant's needs, and to identify gaps in the local long term support service delivery system. For example, a large number of variances for CBRFs above 15 beds may indicate an insufficient number of smaller more appropriate alternative living situations. The Interagency Long-Term Support Planning Committee may use this information to help plan resource development activities.

This review need not look at every variance individually. Rather the lead agency should summarize requests, noting individually only those in which there has been a significant change in the participant's situation, such as changes in the level of long term support needs or the level of informal supports available, and/or the development of additional types or locations of services that are more appropriate.

Variance Restrictions and Approval Process

Type of Variances	Restrictions	Approval
Community-based COP services to a participant who currently resides in an institution	<ul style="list-style-type: none"> • For 90 days only • Specific to each participant and a copy of approval in participant's file • In accordance with a discharge plan, up to 90 days prior to discharge • 1 variance per person per year, not renewable in a single year 	LTS Planning Committee
Community-based COP services to a current participant who is receiving recuperative services in an institution	<ul style="list-style-type: none"> • Specific to each participant and a copy of written approval in participant's file • Up to 90 days for each admission, no variance needed for stays of less than 30 days 	LTS Planning Committee
Provide adult day care or other services in an institution to a participant residing in the community	<ul style="list-style-type: none"> • Specific to each participant and a copy of written approval in participant's file • Overnight stays in a nursing home not allowable 	LTS Planning Committee & written Area Administrator approval
Provide care in a CBRF larger than 8 beds	<ul style="list-style-type: none"> • Specific to each participant and a copy of written approval in participant's file • Smaller living arrangements have been investigated and attempted and participant prefers this • County documents that smaller arrangements are not possible or appropriate to participant's needs • Documentation not needed if the CBRF "beds" consist entirely of independent apartments • Participants in 9 – 15 bed CBRFs prior to January 1, 1996 grandfathered (no variance required) 	LTS Planning Committee & written Area Administrator approval
Allow the county program to exceed the allowable average COP service cost	<ul style="list-style-type: none"> • For one year only 	LTS Planning Committee & written BLTS approval
Allow the county program to exceed the 7% limit on administrative expenses	<ul style="list-style-type: none"> • For one year only 	LTS Planning Committee & written BLTS approval