

**STATE OF CALIFORNIA**  
**ASSISTED LIVING WAIVER**  
**HOME HEALTH AGENCY**  
**2009**  
**PROVIDER**  
**HANDBOOK**  
**REVISED 7/1/2013**

# Assisted Living Waiver Home Health Agency Provider Handbook

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## 1. INTRODUCTION

Welcome and congratulations! You are now a provider for the Assisted Living Waiver (ALW) administered by the Long-Term Care Division, Monitoring and Oversight Section, California Department of Health Care Services. Thank you for joining our team!

As a new partner with DHCS, we want to make sure you know and understand some of our often-used terms: “DHCS” refers to the California Department of Health Care Services — one of several Departments within the California Health and Human Services Agency, DHCS’ mission is to protect and improve the health of all Californians. DHCS staff and contractors are charged to work with clients, providers and communities to make sure quality services are delivered to aged persons and adults with disabilities.

The Assisted Living Waiver Program, sometimes referred to as the ALW Program, offers Medi-Cal eligible individuals the opportunity to receive necessary supportive services in less restrictive and more homelike settings.

You are an important part of the ALW program. You and other service providers enable residents to maintain independence in their own homes —their units in Residential Care Facilities for the Elderly (RCFEs) or apartments in publicly-subsidized housing (PSH).

As a licensed Home Health Agency, you will be responsible for providing Assisted Care Services to ALW beneficiaries in public housing settings. These services include personal care services (including assistance with ADLs and IADLs as needed), chore services, medication oversight and administration, intermittent skilled nursing, and social and recreational programming. Along with your ALW clients, you will also work with Care Coordinators, who assist waiver recipients in gaining access to the services they need. You will, of course, be responsible for complying with all applicable licensing laws and regulations.

To improve the readability of this Handbook, clients/residents are usually referred to residents but may also be called clients, beneficiaries or recipients. For simplicity sake, we have also abbreviated Assisted Living Waiver services by simply saying AL Waiver program or ALW.

## **2. PURPOSE, BACKGROUND AND PROGRAM-SPECIFIC INFORMATION**

### **A. Overview**

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#### **(1) Introduction**

This chapter describes the California's Medi-Cal Assisted Living Waiver (ALW), specifies the authority regulating waiver services, and summarizes the purpose of the program, resident eligibility criteria, and provider qualifications.

Information regarding the ALW can be found on the California Department of Health Care Services' (DHCS) ALW web page:

<http://www.dhcs.ca.gov/services/ltc/Pages/AssistedLivingWaiver.aspx>

The California Medicaid Assisted Living Waiver was initially authorized as a three-year demonstration program by Assembly Bill 499 (Aroner) (Chapter 557, Statutes of 2000).

Medicaid Home and Community-Based Services (HCBS) waiver programs are authorized under Section 1915(c) of the Social Security Act and are governed by Title 42, Code of Regulations (C.F.R.), Part 441.300. The Assisted Living Waiver has been renewed and approved by the Centers for Medicare & Medicaid Services for five years, 2009 through 2013.

Medicaid Home and Community-Based Services (HCBS) waiver programs are authorized under Section 1915(c) of the Social Security Act and are governed by Title 42, Code of Regulations (C.F.R.), Part 441.300.

### **B. What is the Assisted Living Waiver (ALW)?**

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#### **(1) Background**

The ALW is a program that has demonstrated that assisted living services reimbursed by Medi-Cal can be provided in a manner that assures the safety and well-being of beneficiaries and that the provision of these services constitutes a cost-effective alternative to long-term placement in a nursing facility.

There are two implementation models for the Project.

- In the first model, Assisted Living services are provided to participants who reside in Residential Care Facilities for the Elderly (RCFEs). In this model, services are delivered by the RCFE staff.
- In the second model, Assisted Living services are provided to participants who reside in publicly subsidized housing (PH). In this model, services are delivered by Home Health Agency staff.

The ALW has been financed using a Medicaid (Medi-Cal) Home and Community-Based Services (HCBS) waiver.

## (2) Purpose

The goal of the pilot project is to enable Medi-Cal-eligible seniors and persons with disabilities who require nursing facility care, but can be served safely and appropriately outside of a facility, to remain in or relocate to community settings. This goal is accomplished by providing an assisted living benefit and other services.

## (3) Key Program Components

Assisted living meets residents' personal care, support and health care needs while maximizing their autonomy and independence and preserving their ability to exercise choice and control. By responding to their particular and changing needs, assisted living supports residents as they age in place and minimizes their need to move.

Assisted living services are provided to all enrolled clients and are delivered in either a RCFE or a public housing apartment. In PSH residences, Assisted Care is provided by Medi-Cal licensed Home Health Agencies (HHAs).

In addition to the Assisted Care services, ALW waiver benefits also include:

- Care coordination;
- Nursing facility transition care coordination

All home and community based waiver programs must meet the following two requirements:

- ✓ All enrolled clients **MUST** demonstrate needs that would result in placement in a nursing facility were it not for the provision of ALW waiver services; and
- ✓ The cost of providing care **CANNOT** exceed the cost of care that would have been provided had the client been a patient in a nursing facility.

## C. Who Can Receive Services?

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### (1) Introduction

The ALW offers eligible persons a choice between entering a Nursing Facility (NF) **or** receiving necessary supportive services in a less restrictive and more home-like setting. Medi-Cal can reimburse providers for services they deliver to eligible Medi-Cal recipients who are enrolled in the ALW and reside in ALW-participating sites.

## **(2) Eligibility Criteria**

There are certain eligibility criteria that must be met in order to receive services as an ALW client. These eligibility criteria are:

- (a) Enrolled in the Medi-Cal program;
- (b) Have care needs equal to those of Medi-Cal-funded residents in Nursing Facilities (See the Nursing Facility Levels of Care section below);
- (c) Facilities approved to participate in the ALW must be located in one of the counties providing ALW services as indicated:
  - (i) Sacramento, San Joaquin and Los Angeles Counties,
  - (ii) Fresno, San Bernardino and Riverside Counties,
- (e) Able to be served within the ALW cost limitations and,
- (f) Able to reside safely in this setting.

ALW services will NOT be furnished to individuals who are inpatients of a hospital, Nursing Facility, or Intermediate Care Facility for the Mentally Retarded.

## **(3) Nursing Facility Levels of Care**

There are two types of nursing facilities, those licensed for level A residents and those licensed for level B residents. Nursing Facility A (NF-A) facilities are Intermediate Care Facilities (ICF); Nursing Facility B (NF-B) facilities are Skilled Nursing Facilities (SNF). The level of care (LOC) standards for NF-A and NF-B facilities are set forth in Title 22 of the California Code of Regulations.

ALW Care Coordinators determine an applicant's functional eligibility for the program by verifying that the individual meets the level of care determination (i.e., the applicant requires the level of care that is delivered in either a NF-A or NF-B facility). The initial evaluation and periodic reevaluations of the need for a nursing facility level of care are conducted to establish that there is a reasonable indication the client would be eligible for nursing facility placement but for the availability of home and community-based services.

Individuals requiring one of these levels are distinguished as follows:

- (a) Individuals Needing Nursing Facility Level A (NF-A)
  - (i) Require protective and supportive care, because of mental or physical conditions or both, above the level of board and care.
  - (ii) Do not require continuous supervision of care by a licensed registered or vocational nurse except for brief spells of illness.

(iii) Do not have an illness, injury, or disability for which hospital or skilled nursing facility services are required.

- (b) Individuals Needing Nursing Facility Level B (NF-B)
- (i) Require the continuous availability of skilled nursing care provided by licensed registered or vocational nurses.
  - (ii) Do not require the full range of health care services provided in a hospital as hospital acute care or hospital extended care.

#### **(4) Clients Who Cannot be Safely Maintained in the Community**

Some potential participants may require more care than can be safely provided through the ALW. The following conditions automatically render an individual ineligible to participate in the ALW in a PH setting:

- (a) Active communicable tuberculosis;
- (b) Bi-Pap dependency without the ability to self-administer at all times;
- (c) Coma;
- (d) Continuous IV/TPN therapy (TPN, or Total Parental Nutrition, is an intravenous form of complete nutritional sustenance);
- (e) Nasogastric tubes;
- (f) Wound Vac therapy (a system that uses controlled negative pressure, vacuum therapy, to help promote wound healing);
- (g) Restraints except as permitted by the licensing agency;
- (h) Stage 3 or 4 pressure ulcers;
- (i) Ventilator dependency; and
- (j) The need for a two-person transfer, as follows:
  - (i) Beneficiaries must be able to be mobilized to a chair or wheelchair with the assistance of not more than one attendant.
  - (ii) While this provision does not restrict the use of more than one staff member to safely mobilize or transfer a resident when providing routine care, clients may not require transfer or mobility assistance from more than one person in the event of an emergency requiring evacuation.

### **D. Who Can Provide ALW Services?**

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#### **(1) Requirements for ALW Service Providers**

Medi-Cal contracts with Home Health Agencies (HHAs) and Care Coordination Agencies (CCAs) to provide services to ALW clients in public housing settings. Other providers of waiver benefits may contract directly with Medi-Cal **or** they may choose to submit invoices through the beneficiary's Care Coordinator.

All service providers are required to meet minimum standards in order to participate in the ALW. Provider qualifications are verified during the application process and on the provider's anniversary date.

## **(2) Requirements for HHAs**

All providers of assisted care services in public housing settings (HHAs) must:

- (a) Be able to provide the AL Waiver benefit as described above and meet the care needs of all participants by delivering all services at all tiers of care.
- (b) Be able to care for cognitively impaired residents.
- (c) Be able to meet the daily needs of non-English speaking clients without having to access the translation and interpretation benefit.
- (d) Possess a State of California business license, be licensed as a Home Health Agency in California, and be certified as a Medi-Cal provider of home health services.
- (e) Be in substantial compliance with all licensing regulations and in good standing with the licensing agency.
- (f) Open a branch office in the publicly funded housing site where Assisted Care is provided.
- (g) Provide an adequate number of trained staff to meet the needs of clients, with awake staff available 24 hours a day, 7 days per week.
- (h) Provide an emergency response system that enables participants to summon assistance from personal care providers.
- (i) Have a mandatory in-service training program for staff and document staff attendance at all training programs.
- (j) Have a process for soliciting and/or obtaining feedback from clients regarding their satisfaction with services.
- (k) Have a quality assurance program that allows the tracking of client complaints and incident report, including reports of abuse, neglect or medication errors.
- (l) Have a contingency plan to deliver services in the event of a disaster or emergency.
- (m) Enter into an agreement with public housing entities where services are delivered regarding the use of space, access to the building and access to residents. An agreement regarding meals may be included.

- (n) Maintain a service record for each resident. Records, at a minimum, must include a care plan signed by the resident and progress notes. Agencies agree to make those records available to DHCS for audit.
- (o) Agree to collect data as specified.

### 3. COVERED SERVICES

#### A. Introduction

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This chapter describes the services covered under the California Assisted Living Waiver (ALW).

#### B. Description of ALW Benefits

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ALW waiver benefits for participating residents of publicly funded housing include:

- Care coordination;
- Assisted care services

##### (1) Care Coordination

Every ALW enrollee has a Care Coordinator, who is responsible for identifying, organizing, coordinating, and monitoring services needed by the recipient. The Care Coordinator assists waiver recipients in gaining access to waiver services, state plan services and other community resources. Services provided or coordinated by Care Coordinators include:

- (a) Enrolling clients;
- (b) Conducting assessments using the ALW Assessment Tool;
- (c) Determining each client's level of care (i.e. tier);
- (d) Developing Individualized Service Plans (ISPs) using the ALW ISP form;
- (e) Arranging for Waiver, state plan and other services as determined necessary by the assessment;
- (f) Monitoring service delivery;
- (g) Helping transition clients from nursing facilities to RCFEs or public housing setting;
- (h) Maintaining progress notes and case records for each enrolled client;
- (i) Adhering to the prescribed schedule of client contact;
- (j) Receiving complaints from clients, families or friends and forwarding complaints to DHCS;

- (k) Reporting all signs of abuse or neglect to the Ombudsman or APS; and
- (l) Arranging for payment for vendors who opt not to bill Medi-Cal directly.

**(2) Assisted Care Services**

Services provided or coordinated by Home Health Agency staff for ALW residents in public housing include:

- (a) Developing a care plan for each resident detailing, at a minimum, the frequency and timing of assistance. Residents must be a part of the development process and must sign the care plan.
- (b) Providing personal care and assistance with ADLs sufficient to meet both the scheduled and unscheduled needs of the residents;
- (c) Washing, drying and folding all laundry;
- (d) Performing all necessary housekeeping tasks;
- (e) Providing three meals per day plus snacks. Agencies may, in conjunction with the public housing site, coordinate the provision of communal meals. If communal meals are provided, residents are responsible for funding the purchase of raw food. Regardless of where the meals are served, food must meet minimum daily nutritional requirements and special diet needs as prescribed by the PCP must be accommodated;
- (f) Providing intermittent skilled nursing services as required by residents;
- (g) In accordance with State law, providing assistance with the self-administration of medications or, as necessary, administering medications;
- (h) Providing or coordinating transportation;
- (i) Providing or coordinating daily social and recreational activities;
- (j) Providing an emergency response system that enables waiver beneficiaries to summon immediate assistance from personal care providers.

### **(3) Medi-Cal State Plan Services**

ALW participants are entitled to use all Medi-Cal state plan benefits including all primary, preventive, specialty, acute care and pharmaceutical services. Participants are not to use in-home supportive services as these services are being provided through the Assisted Care Services by HHAs.

Participants requiring short-term placement in a skilled nursing facility to recuperate from an acute episode will return to their primary residence (i.e. the PH site) and continue enrollment in the ALW. Participants requiring long-term placement in a skilled nursing facility will be terminated from the project.

### **(4) Other Community Resources**

Care Coordinators are expected to refer ALW enrollees to or arrange for enrollees to participate in services funded through the Older Americans Act or other reimbursement sources as determined to be necessary by the ALW Assessment. Examples of appropriate services might include legal services, money management services, or friendly visiting.

## **C. Program Requirements**

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### **(1) Resident Privacy**

All ALW clients have a right to privacy. Residences may be locked at the discretion of the client, except when a physician or mental health professional has certified in writing that the client is sufficiently cognitively impaired as to be a danger to self or others if given the opportunity to lock the door. (This requirement does not apply where it conflicts with the fire code.)

### **(2) Client-Directed Care**

The Assisted Living benefit was designed to be a client-directed service. Persons with cognitive disabilities will direct their own care to the best of their ability. Clients who are not able to direct the development of their own care and participate in the oversight of their own services may be assisted by a family member or other responsible party, such as a legal conservator. The person(s) responsible for the client's health care decisions may assume a lead role in ISP or care plan development and oversight in collaboration with the provider and the Care Coordinator as necessary.

## **D. Exclusions**

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Payment made by Medi-Cal for Assisted Care Services provided by HHAs in public housing settings CANNOT be used to pay for rent or the purchase of food. Rent and food are paid for by the resident.

Units provided by the public housing entity will include living/sleeping space, bathrooms, and kitchen areas equipped with a refrigerator, cooking appliance, and storage space for utensils and supplies. The refrigerator and cooking appliance must be placed in a location that allows for easy access by clients. The housing sites will also have common space adequate for the provision of all required services (e.g. meals, socialization and activities), either on-site or at a convenient and accessible off-site location. Medi-Cal funds may not be used to furnish provide for common area space.

## **E. Leave of Absence and Discharge**

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### **(1) Introduction**

AL Waiver recipients must reside in a setting served by an ALW Primary Service Provider in order to receive AL Waiver services. A recipient that is not a resident of either an AL waiver contracted RCFE or a publicly-subsidized housing setting served by a contracted HHA cannot receive AL Waiver services even if all other eligibility criteria are met.

### **(2) Leave of Absence**

If ALW recipients are absent from their primary residence (e.g., public housing setting) for more than 24 hours for health or personal reasons, AL Waiver Services are not being provided and may not be billed.

### **(3) Discharge From a PH Site**

If a public housing site evicts an AL Waiver recipient, prior notification must be given to the client's Care Coordinator. The eviction must be carried out in accordance with the terms of the lease and HUD regulations if the building is governed by HUD requirements.

### **(4) Move to Another ALW Setting**

If a recipient requests to move or is moved from one AL Waiver setting to another AL Waiver setting, the discharging AL Waiver service provider assists in coordinating the placement, and the recipient remains eligible to receive AL Waiver services in the new setting.

Any time a change in AL Waiver service provider is necessary, the change must be coordinated with the recipient's Care Coordinator.

**(5) Move to a Non-ALW Setting**

Changes in residence for an AL Waiver recipient must be coordinated with the Care Coordinator. If it appears that a nursing facility or other placement is necessary, the facility must coordinate with the Care Coordinator and jointly develop a plan to seek an appropriate placement.

**F. Termination of Assisted Living Waiver Services**

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**(1) Introduction**

In most cases, AL Waiver recipients must be given a written 10-day advance notice of termination that includes information on their right to request a fair hearing. This notice should not be confused with any notice required by applicable law to pursue eviction of a resident from public housing. A resident who is terminated from the ALW is not prohibited from remaining in the PH setting.

**(2) Criteria for Denial or Termination of ALW Services**

- (a) Enrollment in the ALW may be denied or terminated when any one of the following circumstances occur:
  - (i) The client elects in writing to terminate services;
  - (ii) The client elects to receive services through a different Home and Community-Based waiver program;
  - (iii) The client's health care needs no longer meet the level of care necessary to qualify for the Assisted Living Waiver program;
  - (iv) The client's Medi-Cal eligibility and/or aid code changes, such that he or she is no longer eligible to participate in the waiver;
  - (v) The cost of waiver services plus state plan benefits exceeds the cost of care in the alternative nursing facility setting;
  - (vi) The client is unwilling or unable to comply with his or her Individual Service Plan;
  - (vii) The waiver service provider is unwilling or unable to provide the amount of authorized services as requested by the ISP and /or physician order, and the client, despite the full assistance of the Care Coordinator and the Department of Health Care Services, is unable to arrange for another waiver service provider; and/or,
  - (viii) The client is unable to maintain health, safety, and/or welfare in the assisted living setting as determined by the Care Coordinator in conjunction with the resident, the HHA, the resident's family, the resident's physician, and/or others as appropriate.

- (b) When waiver services are denied, reduced or terminated, a notice of action will be forwarded to the client by the Health Care Operations Division (MCO) of DHCS in conformance with Title 22, 50952 and 51014.1
- (c) In the event a provider is no longer capable of meeting the needs of an ALW client, the Care Coordinator in conjunction with DHCS assists in the emergency relocation of the client and/or in securing another provider to meet the client's needs. ***ALW providers may not discharge a resident simply because the resident requires care at a higher service tier. Providers are expected to serve residents at all service levels unless they exceed the admission/retention criteria outlined in Chapter 5, Section A.*** Providers must receive the approval of an ALW resident's Care Coordinator (and DHCS) before initiating any termination or discharge procedures.

If an ALW client voluntarily chooses to withdraw from the ALW, the client should contact his/her Care Coordinator to initiate the withdrawal process.

Any deposits paid for with waiver monies must be returned to Medi-Cal when the beneficiary leaves the PH residence. These monies are reimbursed to the Medi-Cal Estate Recovery Unit and the Medi-Cal Overpayments Unit.

### **(3) Right to a Fair Hearing**

Beneficiaries may be given written notice by DHCS at least 10 days prior to action by the Department that denies, reduces or terminates services. Upon receipt of written notice, beneficiaries have the right to appeal the intended action of the Department through the Fair Hearing Process as per Title 22, CCR 51014.01.

## 4. THE ALW PROCESS

### A. Introduction

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Care Coordinators are expected to coordinate all of the waiver, state plan and community resources needed to enable a client to continue living in the community. Services are delivered pursuant to an assessment and the development of a service plan. Service provision is routinely monitored and clients are reassessed every six months.

### B. Overview of the ALW Process

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The ALW process includes the following activities performed in the order in which they are listed.

- (1) Referral of a potential ALW client to a Care Coordinator;
- (2) Screening of the applicant to determine whether to conduct an assessment;
- (3) Verification of Medi-Cal eligibility;
- (4) Assessment of the client using the ALW assessment tool;
- (5) Choosing the ALW;
- (6) Development of an Individual Service Plan (ISP);
- (7) Enrollment of the client in the ALW;
- (8) Selection by the client of a public housing site that is contracted with a participating HHA;
- (9) Assessment of the client by the HHA;
- (10) Development of a Care Plan by the HHA;
- (11) Transition by the client to the PH setting (if not already residing in that location);
- (12) Provision, oversight and monitoring of services; and
- (13) Frequent reassessment of the client.

- (14) Work in conjunction with the Money Follows the Person (MFP) program in California to assist with the successful placement into the ALW of persons identified by the MFP who choose the ALW.

### **C. Referral of Potential ALW Clients**

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In each county in which the ALW is implemented, Care Coordinators engage in outreach and case finding activities to inform the community of the existence of the program and establish working relationships with potential sources of referral. These referral sources may include:

- Discharge planners in acute care hospitals;
- Staff of the Money Follows the Person (MFP) program in California to assist with the successful placement into the ALW of persons identified by the MFP who choose the ALW.
- Discharge planners in long-term care facilities;
- County-based In-Home Supportive Services (IHSS) programs;
- Medi-Cal Field Office staff;
- Home health agencies, social service agencies, physicians and other home health a community providers; and
- Potential clients and their families.

The referral of potential clients to the ALW may be initiated by contacting a participating Care Coordination Agency. A list of all ALW Care Coordination Agencies may be found on the California Department of Health Care Services' (DHCS) ALW web page:

<http://www.dhcs.ca.gov/services/ltc/Pages/AssistedLivingWaiver.aspx>

### **D. Screening Prior to Assessment**

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When individuals are referred to Care Coordinators, a screening process is used to identify potential applicants who clearly do not require a NF level of care or who clearly require more care than is allowed in the ALW (e.g., if individuals have no ADL deficiencies or condition listed in Chapter 5, Section A, that automatically renders them ineligible for the project).

If it is determined via the screening process that a potential participant does not meet the ALW admission criteria, a full assessment would not be conducted.

The screening process does **NOT** determine a potential client's level of care. The determination of a client's level of care can only be made when a Care Coordinator administers and scores the ALW Assessment Tool.

## **E. Verification of Medi-Cal Eligibility**

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The Care Coordinator verifies a potential client's Medi-Cal eligibility by referring to one or more of the following sources of information:

- Medi-Cal Eligibility Data System (MEDS) screen print;
- Certification from the Claims and Real Time Eligibility System (CERTS) or the Automated Eligibility Verification system (AVES). Both of these systems are available to Medi-Cal Providers through the Medi-Cal Fiscal Intermediary-ACS Xerox; and/or
- A county-issued immediate need Medi-Cal card.

Applicants who appear eligible for Medi-Cal, but are not receiving benefits, are referred by the Care Coordinator to their county social service office for Medi-Cal eligibility determination. Individuals already receiving SSI/SSP payments are automatically eligible for Medi-Cal as arranged by the local Social Security Administration office.

Individuals who have not applied for Medi-Cal must complete (or have a designated representative complete) and submit a Medi-Cal application to their local county social service office listed at:

<http://www.dhcs.ca.gov/provgovpart/county/Pages/default.aspx>

More information about Medi-Cal, including answers to frequently asked questions, is available at this DHCS Medi-Cal web page:

<http://www.dhcs.ca.gov/services/medi-cal/Pages/default.aspx>

Once the applicant has been enrolled in the Medi-Cal program, care coordinators may proceed with the enrollment process.

Care Coordination agencies are responsible for verifying client eligibility by the first of each month.

## **F. The Assessment Process**

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### **(1) Purpose**

Once a client's Medi-Cal eligibility has been established, the Care Coordinator conducts an assessment to determine the client's level of care and capacity to live independently. The assessment also determines the services that are needed for the applicant to safely sustain residence in the community with as much independence as possible. Assessment precedes enrollment in the ALW;

until the applicant is assessed and a care plan is developed, s/he cannot be enrolled in the ALW.

## **(2) The Assessment Process**

The assessment process requires a face-to-face interview with the Care Coordinator and the client and, as appropriate, contact with the family, legal representatives and/or other informal supports. Clients and family are expected to remain involved in the assessment and care planning process.

The ALW Assessment Tool is used to conduct the assessment, with points assigned based on the applicant's response to specific questions. The total number of points assigned determines the applicant's level of care.

## **G. Service Level ("Tier") Determination**

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### **(1) Overview**

The primary AL waiver benefit is delivered to residents in one of four possible "tiers" of service intensity as determined by the ALW Assessment Tool. Payment rates for assisted care services are based on each resident's current service level (see Appendix I).

### **(2) Description of Service Tiers**

Tier one applies to residents with the lowest level of support need; tiers two and three services apply to residents with more significant support needs, respectively. Tier four services are provided to residents with the most intense support needs who are eligible for the ALW.

### **(3) Reassessment Schedule**

The Care Coordinator is responsible for reassessing each client every six months or upon significant changes in condition. The level of service (i.e. tier) is also reevaluated, and modified as needed, at this time.

## **H. Choosing the ALW**

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Once the applicant has been determined to need a NF level of care, the Care Coordinator is required to provide the prospective client with information about nursing home care and community-based alternatives to NF care. Care Coordinators must tell applicants they have the right to choose residence in a nursing facility, apply for services from another waiver program, or enroll in the ALW.

Care Coordinators must also provide the consumer with copies of the Freedom of Choice Letter and the Freedom of Choice Document. The consumer must sign the Freedom of Choice document, which verifies that information about community-based alternatives to nursing homes has been provided and the consumer has chosen to participate in the ALW.

## **I. Developing an Individual Service Plan**

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### **(1) Purpose**

Once clients have documented their choice to participate in the ALW, the Care Coordinator develops a plan that addresses identified needs, outcomes to be achieved, and services to be provided in support of goal achievement. This plan provides a focus for the needs identified in the assessment; organizes the delivery system for the client; and helps assure that the services being delivered are appropriate to the client's needs.

### **(2) Format**

The result of this process is the development of an Individual Service Plan (ISP) that:

- Identifies the client's needs;
- Specifies the intervention or service that will be provided to address each need;
- States the goal and anticipated outcome of each intervention;
- Identifies the name and phone number of each provider of service;
- States the date each service is expected to begin and end (if the service will be time-limited instead of ongoing);
- Specifies the funding source for the service if it is not a waiver benefit (e.g. a service may be paid for by Medi-Cal state funds or provided without charge by a community-based non-profit organization);
- Documents any disagreement the client has with any part of the plan, along with the resolution of the disagreement; and
- Lists all participants of the ISP team.

The ISP is operative until six months after the date of the assessment or until the client experiences significant changes in his/her condition. Copies of the ISP are provided to the resident, the resident's family or guardian, as appropriate, and the HHA providing the assisted living benefit in the PH setting.

## **J. Enrollment of the Client**

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### **(1) The Enrollment Process**

To enroll a client, the Care Coordinator submits to DHCS the name of the enrollee, the enrollee's completed, signed, and scored Assessment Form, and the client's completed and signed ISP.

**(2) Verification of Enrollment**

DHCS then faxes/e-mails notification of enrollment to the Care Coordinator. DHCS also sends an Informing Notice to the client that specifies the roles and responsibilities of the beneficiary, the Care Coordinator, the provider, and the physician.

All clients must be enrolled into the Assisted Living Waiver prior to billing.

**K. Transitioning to an ALW Participating Site**

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**(1) Selection of an ALW Participating Site**

The Care Coordinator is responsible for assisting ALW clients in selecting PH sites to which they will move (or continue to reside). Family members, friends and/or legal representatives should be encouraged to visit identified facilities with clients to assist in the selection process.

**(2) Acceptance by the HHA**

Participating HHAs are not required to accept every ALW client who selects their agency, although all ALW service providers are required to serve residents at all service tiers. Facilities may choose to not accept clients who have needs that would likely not be best served in that location (e.g. a client who has a history of wandering in a residence located on a busy street with fast-moving traffic).

**(3) Residents Who Move From a Nursing Home**

Clients who move from a nursing facility may access funds from a Community Transition benefit to aid, as needed, in their transition to the community (see Chapter 3 Section B 3 for a full description of the use of these funds). Care Coordinators are responsible for arranging the services or purchasing the items that are reimbursed from this fund.

**L. Site-Specific Service Plans**

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**(1) Purpose**

HHA's participating in the ALW are responsible for developing an individualized care plan for each resident that provides detailed information about the services that will be provided by the HHA. The care plan is used by the HHA staff to

provide services that are individualized to each resident and are in accordance with the ISP developed by the Care Coordinator.

## **(2) Process**

The care plan developed by the HHA will be based on the assessment conducted by the agency and on the ISP developed by the Care Coordinator for the client. While the ISP provides general information about the services that will be provided for the client, the care plan developed by the service provider includes more detailed information about the services that will be provided (specifying at a minimum the frequency and timing of assistance to be provided).

For example, the ISP developed by the Care Coordinator might state that the service provider will assist the client with showers. The care plan developed by the HHA would provide additional details about the provision of this service (e.g. staff will provide assistance with showers on Monday, Wednesday and Friday at 6:30 a.m., helping the resident into the shower and providing stand-by assistance while he/she showers).

Following are general guidelines for the development of care plans:

- Services should be planned and delivered in a manner that meets clients' needs and preferences;
- Clients have the right to participate in the development of their service plans to the full extent of their ability;
- **Care plans must be signed by the participant.** A copy of a signed care plan must be retained in the client's file;
- Care plans must be completed within no more than one week from a client's acceptance by the HHA as an ALW client; and
- Care plans developed for ALW clients must meet all applicable licensing/regulatory requirements for HHAs.

## **M. Service Delivery**

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### **(1) The Role of the Care Coordinator**

Care Coordinators are responsible for arranging for the provision of all needed services as identified on the client's ISP. This includes all waiver benefits, all Medi-Cal State Plan services, and all services provided by community resources.

### **(2) The Role of the HHA**

HHAs are responsible for providing services as indicated on the ISP developed by the Care Coordinator and on the care plan developed by the HHA. As

needed, the provision of these services should be coordinated with services provided by other service providers arranged by the Care Coordinator.

## **N. Monitoring Service Delivery**

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### **(1) Purpose**

The Care Coordinator is responsible for monitoring the delivery of services for ALW clients. This is accomplished through contact with the client to determine if the services provided are meeting the client's needs and whether the client is satisfied with the provision of services.

### **(2) Schedule for Contact with Clients**

Care Coordinators are required to have contact with ALW clients according to the following schedule, at a minimum:

- ✓ Face-to-face visit every 30 days
- ✓ Assessment visit every 6 months

### **(3) Incidents and Concerns**

HHAs participating in the ALW are expected to comply with all reporting requirements mandated by regulation (e.g. for incidents, suspected abuse, etc.). Participating HHAs must also forward to residents' Care Coordinators any reports that have been submitted to the licensing agency. In addition, HHAs must report to a resident's Care Coordinator any concern expressed by the resident, the resident's family and/or others that indicate the resident may be at risk. Such concerns must be reported to the Care Coordinator within 24 hours of receipt and must be documented in the resident's record.

### **(4) Signs of Abuse or Neglect**

If a resident exhibits any sign of abuse or neglect, the HHA should follow all licensing requirements for reporting the suspected abuse or neglect. The service provider is also required to notify the resident's Care Coordinator.

## **O. Reassessment**

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### **(1) Timeline**

Reassessments are performed by the Care Coordinator every six months, or when the client experiences a significant change in condition.

**(2) Process**

When reassessing a client, Care Coordinators conduct another complete assessment using the ALW assessment tool. In addition, a new ISP is developed and the updated level of care recorded on the new ISP. The updated Assessment and ISP is faxed by the Care Coordinator to DHCS.

## 5. PROVISION FOR SKILLED NURSING NEEDS

### A. Prohibited Health Conditions

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Some individuals who are at the nursing facility LOC may not be served in the ALW because their conditions and care needs are beyond the scope of the assisted living benefit. For individuals residing in a public housing setting, these prohibited health conditions include:

- (a) Active communicable tuberculosis;
- (b) Bi-Pap dependency without the ability to self-administer at all times;
- (c) Coma;
- (d) Continuous IV/TPN therapy (TPN, or Total Parental Nutrition, is an intravenous form of complete nutritional sustenance);
- (e) Nasogastric tubes;
- (f) Wound Vac therapy (a system that uses controlled negative pressure, vacuum therapy, to help promote wound healing);
- (g) Restraints except as permitted by the licensing agency;
- (h) Stage 3 or 4 pressure ulcers;
- (i) Ventilator dependency; and
- (j) Two-person transfers, as outlined below:
  - a. Potential beneficiaries must be able to be mobilized to a chair or wheelchair with the assistance of not more than one attendant.
  - b. While this provision does not restrict the use of more than one staff member to safely mobilize or transfer a resident when providing routine care, clients may not require transfer or mobility assistance from more than one person in the event of an emergency requiring evacuation.

Individuals who have any these conditions will not be accepted for enrollment in the ALW. If an ALW client develops one or more of these conditions, the service provider should contact the Care Coordinator to arrange for transfer to a more appropriate level of care.

#### (1) Temporary Conditions

If a waiver client develops a prohibited health condition that is thought to be temporary, the resident may be transferred to a higher level of care until the condition has been managed. The HHA should coordinate the transfer with the Care Coordinator, and may not bill Medi-Cal for the days that the resident is away from the residence.

#### (2) Permanent Conditions

If a resident develops a prohibited health condition that is determined to be permanent in nature, the resident is no longer appropriate for the ALW and the

HHA should contact the resident's Care Coordinator to facilitate a transfer to another setting.

## **B. Documentation**

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All care provided by an appropriately skilled professional, including skilled nursing care provided by licensed nursing staff must be documented in the resident's file. These records must be made available for inspection by DHCS upon verbal or written request.

## 6. RECORDS AND DATA COLLECTION

### **A. Documentation**

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ALW service providers must document in resident files as required by applicable licensing agencies. In addition, HHAs must document any excessive refusals of service by ALW clients.

### **B. Confidentiality**

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The names of persons receiving services through the ALW are confidential and are protected from unauthorized disclosure. All client-related information, records, and data elements must be protected by the service providers from unauthorized disclosure.

### **C. Data Collection**

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As the AL Waiver program is a pilot project, DHCS is responsible for preparing and submitting an evaluation of the project to the State Legislature. The Legislature will then determine whether to continue and/or expand the project. Data is essential to the development of the report.

Therefore, ALW service providers may be requested to submit data regarding participating residents to DHCS. It is essential that any data submitted be accurate and complete and submitted within the specified time frame.

### **D. Storage of Records**

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Each participating HHA is responsible to maintain and store all information obtained on each ALW client for a minimum of three years.

## 7. QUALITY ASSURANCE

### A. Quality Assurance Plans

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Participating HHAs are required to develop and maintain a quality assurance plan to track the following issues:

- ✓ Client complaints;
- ✓ Incident reports, including abuse, neglect and medication errors;
- ✓ Required staff training; and
- ✓ Contingency plan(s) to provide services in case of a disaster or emergency where the scheduled staff is not available.

### B. Opportunities for Client Feedback

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ALW service providers are also required to provide clients with opportunities to offer feedback regarding their level of satisfaction with services. Examples of such opportunities include:

- ✓ Suggestions boxes;
- ✓ Satisfaction surveys; and
- ✓ Resident council meetings.

### C. ALW-Wide Quality Assurance Measures

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As part of an overall quality assurance plan, DHCS will conduct annual audits of ALW service records, including the provider's care plans and progress notes.

DHCS will also conduct Participant Experience Surveys to obtain feedback from participants about their experience in the waiver program.

## 8. BILLING AND REIMBURSEMENT

### A. Overview

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Participating HHAs submit monthly billings to DHCS for services provided to ALW clients. Room and board payments (for rent and the cost of food) are paid directly by residents (see Section D below for more information on room and board payments).

### B. Service payments

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#### (1) Overview

ALW providers bill DHCS directly, using the **UB-04** billing form. Treatment Authorization Requests (TARs) are NOT required.

Participating HHAs use four codes for billing, which correspond to the four service tiers. Each tier is paid at a different payment rate (see Appendix I for the current rate structure).

Only providers enrolled in the Medi-Cal system can successfully submit claims for services, and providers may only bill for residents who are already enrolled in the ALW.

#### (2) The Billing Process

- (a) Each provider must submit a billing statement that specifies the service provided, the procedure code for the service, the dates of service, the number of units of service provided (i.e. the number of days services were provided), the rate per unit, and the total charge.
- (b) The billing statement must also specify the tier of service provided as determined by the most recently completed assessment and recorded on the most recently completed ISP.
- (c) Invoices are submitted to the Fiscal Intermediary, ACS-Xerox. Providers should bill at the end of each month for services provided during that month.

### C. Billable Days for AL Waiver Services

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- (a) Reimbursement will be made only for days the resident is eligible for and is receiving services in the facility.

- (b) Reimbursement will not be made when the recipient is absent for 24 hours or more. In such cases, reimbursement will be made for the day the resident returns, but not the day the resident leaves.

## **D. Room and Board Payments**

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Medi-Cal does not pay for Room and Board expenses. Each resident is financially responsible for his/her own Room and Board and should be contacted directly for payment. Residents may pay Room and Board with funds they receive from any of several sources such as Social Security benefits, Supplemental Security Income (SSI), State Supplemental Payment (SSP), or other personal income sources.

Clients in PH settings are responsible to the property manager or building owner for rent expenses; they are also responsible for paying for food and other living necessities, although assistance in preparing food is provided by HHAs.

## **E. Completing the UB 04 Form**

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### (1) Overview

ALW providers will bill DHCS directly using the **UB-04** billing form. A Treatment Authorization Request (TAR) is **NOT** required.

Only providers enrolled in the Medi-Cal system can successfully submit claims for service and providers may only bill for clients already enrolled in the ALW.

### (2) Process

- (a) You must submit a **UB-04** form for each participant. Complete the following fields on the form. Leave the other fields **blank**.

Field 1 Enter your organization name and address, including ZIP Code

Field 3 Although this is an optional field, creating a participant control number will help you identify a participant should you ever need to follow up with a concern regarding your UB-04. Your office's participant record number is a common choice for this field.

Field 4 Enter the number "331" (outpatient health)

Field 12 Enter the participant's last name followed by the first name

Field 13 Enter the participant's address including ZIP code

Field 14 Enter the participant's birth date starting with the month (2 digits), date (2 digits) and year (4 digits).

Field 42 Enter the code "001" on the last detail line (line #23) to designate the total charge line.

Field 43 Enter "Total Charges" in the white box at the bottom of the field.

Field 44 Enter the HCPCS code on the red line (line #2). The codes are:

Tier 1	T2031U1	\$52/ day
Tier 2	T2031U2	\$62/ day
Tier 3	T2031U3	\$71/ day
Tier 4	T2031U4	\$82/ day

Field 45 Enter the service dates in a from/through format. Enter the start date for the month on the white line (line #1) and the end date for the month on the red line (line #2).

Field 46 Enter the number of units of service provided during the billing period on the red line. The assisted living benefit is 1 unit of service per day.

Field 47 Enter the charge corresponding to the service provided on the red line (directly across from the end date for service. At the bottom of the column, line 23, enter the total charge for the month.

Field 50 Enter "O/P Medi-Cal" on line A.

Field 51 Enter your provider number.

Field 60 Enter the 14 digit Medi-Cal BIN number

Field 84 Only use to indicate attachments (rare), or to indicate the patient is over 100 years of age.

Field 85 Sign and date the form in black ink only.

(b) Invoices are submitted to:

MEDI-CAL

Fiscal Intermediary, ACS-Xerox

P.O. Box 15600

Sacramento, CA 95852-1600

## **F. Contacting ACS-Xerox**

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If you need help completing the UB 04, you can call the Provider Support Center at 800-541-5555.

ACS also maintains a Small Provider Billing Unit, a free, full-service billing assistance and training program. Claims processors and regional field representatives work directly with providers in a structured program to assist in completing and submitting Medi-Cal claims. This detailed training program lasts one year. To qualify, you must submit no more than 100 claim lines per month. To contact this unit, call: (800) 541-555 ext 1275.