

APPENDIX A-

MEDICAID HOME AND COMMUNITY-BASED WAIVER SCOPE OF SERVICES FOR COMPANION SERVICES

A. Objectives

The objectives of Companion services are to provide short-term relief for caregivers and to provide needed supervision of Medicaid Home and Community-Based waiver participants.

B. Conditions of Participation

1. Agencies must utilize the automated systems mandated by Community Long Term Care (CLTC) Division to document and bill for the provision of services.
2. Pursuant to enactment and implementation of House Bill 3012 all providers of personal care services will require a license to provide personal care services.
3. Provider agency must be housed in an office that is in a commercial zone. Office can not be located in a residence/home office. Current providers with residential/home offices must relocate to a commercially zoned office space by July 1, 2012 in order to maintain their contract.
4. Providers must accept or decline referrals from CLTC within two (2) working days. Failure to respond will result in the loss of the referral.
5. The provider will be responsible for verifying the participant's Medicaid eligibility when it has accepted a referral and monthly thereafter to ensure continued eligibility. Providers should refer to the CLTC Services Provider Manual for instructions on how to verify Medicaid eligibility.
6. Providers may use paperless filing systems. When using electronic filing systems any documentation requiring signatures must be signed prior to scanning. Electronic records must be made available upon request, and providers must have a reliable back-up system in the event their computer system shuts down.

C. Description of Services to be provided

1. The unit of service is one (1) hour of direct services provided in the participant's residence or away from the participant's residence for shopping, laundry services, other offsite services or escort services. The amount of time

authorized does not include the companion's transportation time to and from the participant's residence.

2. The number of units and services provided to each participant is dependent upon the participant's needs as set forth in the participant's Service Plan.
3. Services to be provided include:
 - a. Socialization - Reading, conversation, assistance with mail and other interaction with participant as appropriate.
 - b. Assistance with or supervision of meal/snack preparation.
 - c. Assistance with or supervision of participant laundry. (Washing clothes & linens)
 - d. Assistance with or supervision of participant's shopping
 - e. Incidental light house keeping. (Dusting, sweeping or other light chores to maintain participant in a safe clean environment.)
 - f. Sitting service focusing on the participant including supervision, orientation, making appropriate contact in case of emergency.

D. Staffing

The provider must maintain individual records for all employees.

1. The provider must maintain the following (supervisory positions may be sub-contracted):
 - a. A supervisor who meets the following requirements:
 - i. High school diploma or equivalent;
 - ii. Capable of evaluating companions in terms of their ability to carry out assigned duties and their ability to relate to the participant; and
 - iii. Able to assume responsibility for in-service training for companions.
 - b. Companions who meet the following minimum qualifications:
 - i. Able to read, write and communicate effectively with participant and supervisor;
 - ii. Able to use the Care Call IVR system;
 - iii. Capable of following a care plan with minimal supervision;

- iv. At least 18 years of age.
- c. Companions must complete four (4) hours of relevant in service training per calendar year in the following areas:
 - 1. Maintaining a safe, clean environment and utilizing proper infection control techniques;
 - 2. Following written instructions;
 - 3. Ethics and interpersonal relationships;
 - 4. Documenting services provided;
 - 5. Other areas of training as appropriate.

The annual four-hour requirement will be on a pro-rated basis during the companion's first year of employment.

- 2. Agency staff may be related to participants served by the agency within limits allowed by the South Carolina Family Caregiver Policy. The following family members cannot be a paid caregiver:
 - 1. The spouse of a Medicaid participant;
 - 2. A parent of a minor Medicaid participant
 - 3. A step parent of a minor Medicaid participant;
 - 4. A foster parent of a minor Medicaid participant;
 - 5. Any other legally responsible guardian of a Medicaid participant

Qualified family members can be reimbursed for their provision of Companion services.

3. PPD Tuberculin Test

Please refer to Department of Health and Environmental Control (DHEC) website, Regulation 61-75 – Standards for Licensing for PPD Tuberculin test requirements. <http://www.scdhec.gov/health/licen/hladcinfo.htm>

Providers needing additional information should contact the Tuberculosis Control Division, Department of Health and Environmental Control, 1751 Calhoun Street, Columbia, S.C. 29201, phone (803) 898-0558.

- 4. A criminal background check will be required for all potential employees to include employees who will provide direct care to CLTC participants and all administrative/office employees (office employees required to have background checks include: administrator, office manager, supervisor, and persons named on organizational chart in management positions) . All criminal background checks must include all data for the individual with no limit on the timeframe being searched. Criminal background checks that cover a seven or ten year period are not acceptable. The criminal background check must include

statewide (South Carolina) data. Potential employees with felony convictions within the last ten (10) years cannot provide services for CLTC participants or work in an administrative/office position. Potential employees with non-violent felonies dating back ten (10) or more years can provide services to CLTC participants under the following circumstances:

- Participant/responsible party must be notified of the aide's criminal background, and
- Documentation must be placed in the participant's record and signed by the participant/responsible party acknowledging awareness of the aide's criminal background and agreement to have the aide provide care.

Potential administrative/office employees with non-violent felony convictions dating back ten (10) or more years can work in the agency at the provider's discretion.

Hiring of employees with misdemeanor convictions will be at the provider's discretion.

E. Conduct of Service

The provider must maintain documentation showing that it has complied with the requirements of this section.

1. The provider must obtain the Service Plan and authorization from the case manager prior to the provision of services. The authorization will designate the amount, frequency and duration of service for participants in accordance with the participant's Service Plan/Authorization which will have been developed in consultation with the participant and others involved in the participant's care. The provider will receive new authorizations only when there is a change to the authorized service. The provider must adhere to those duties which are specified in the authorization in developing the Provider task list. The provider task list must be developed by the supervisor. If the provider identifies Companion duties that would be beneficial to the participant's care but are not specified in the authorization, the provider must contact the case manager to discuss the possibility of having these duties included in the Authorization. **Under no circumstances will any type of skilled medical service or hands on care be performed by a companion.** The case manager will make the decision as to whether the CLTC Service Plan should be amended to include the additional duty. This documentation will be maintained in the participant files.

2. The supervisor of Companion services must:
- a. Perform an initial visit to the participant's home within 90 days of the start of services and provide on-site supervision at least once every 365 days thereafter for each participant and phone contact with the participant or responsible party as needed.
 - b. Each supervisory visit, including the initial visit, will be documented in the participant's file and recorded in Care Call. In the event the participant is inaccessible during the time the visit would have normally been made, the review must be completed within five (5) working days of the resumption of Companion services. The Supervisor's report of the on-site visits must include, at a minimum:
 1. Documentation that services are being delivered consistent with the Service Plan/Authorization;
 2. Documentation that the participant's needs are being met;
 3. Reference to any complaints which the participant or family member/responsible party has lodged; and,
 4. A brief statement regarding any changes in the participant's service needs.
 - c. Supervisors will provide assistance to companions as necessary.
 - d. Supervisors will be immediately accessible by phone and/or beeper during any hours services are being provided under this contract. If the supervisor position becomes vacant, SCDHHS must be notified within two (2) business days.
 - e. If there is a break in service which lasts more than sixty (60) days, the supervisor must conduct a visit within ninety (90) days of the resumption of services.
5. In addition, the provider must maintain an individual participant record that documents the following items:
- a. The provider will initiate Companion services on the date negotiated with the CM and indicated on the authorization. Services must not be provided prior to the authorized start date and must be provided according to the schedule as indicated on the authorization.
 - b. The provider will notify the CM within two (2) working days of the following participant changes:

1. Participant's condition has changed and the Service Plan/Authorization no longer meets participant's needs or the participant no longer appears to need Companion services.
 2. Participant dies, is institutionalized, or moves out of the service area.
 3. Participant no longer wishes to participate in a program of Companion services.
 4. Provider becomes aware of the participant's Medicaid ineligibility or potential ineligibility.
- c. The provider will maintain a record keeping system which documents the delivery of services in accordance with the Service Plan. The provider shall not ask the participant/responsible person to sign any log or task sheet. Task sheets must be reviewed, signed, with original signature (rubber signature stamps are not acceptable), and dated every two (2) weeks by the supervisor. Task sheets must be filed in the participant's record within 30 days of service delivery.
- d. Whenever two consecutive attempted visits occur, the local CLTC office must be notified. An attempted visit is when the companion arrives at the home and is unable to provide the assigned tasks because the participant is not at home or refuses services.
- e. The provider will inform participants of their right to complain about the quality of Companion services provided and will give participants information about how to register a complaint. Complaints which are made against companions will be assessed for appropriateness and for investigation by the provider. All complaints which are to be investigated will be referred to the supervisor who will take any appropriate action.

F. Compliance Review Process

The Division of Long Term Care Waiver Management, Provider Compliance Department has developed this policy for clarification of the provider compliance process. The policy gives detailed information on how provider compliance sanctions are implemented. Provider reviews receive a score based on a sanctioning scale; review scores will determine if the provider will receive a sanction and if so, the level of the sanction. The sanction scoring process was developed to ensure that reviews are equitable and for providers to know what to expect when they are reviewed.

The following chart outlines how reviews are scored:

Sanction Level

- Provider compliance review questions in the Scope of Services are classified into three classes, based on (1) the significance of the question regarding to the services, and (2) the potential influences on providers and participants if the requirement was not met. See the example below:

Severity level: 1=less serious, 2 = serious, 3 = very serious

Client Service Questions	Possible Answers	Severity level
Was supervisory visit made within 30 days after PC II services initiated?	Y,N,NA	3
Was the initial supervisory visit documented in Care Call?	Y,N,NA	3
Does provider maintain individual client records?	Y,N	2
Did provider give participant written information regarding advanced directives?	Y,N,NA	1

There are five types of sanctions:

- Correction Plan – This is the lowest sanction and indicates the provider is in substantial compliance with the contractual requirements. The provider will be required to submit a corrective action plan outlining how and when deficiencies will be corrected (or have been corrected) and outline a plan of how they will avoid future deficiencies
- 30-day suspension – At this level, new referrals are suspended for 30 days. The provider will also be required to submit a corrective action plan. If the corrective action plan is approved, the suspension is automatically lifted at the end of the 30-day period; indicates moderate deficiencies.
- 60-day suspension – At this level, new referrals are suspended for 60 days. The provider will also be required to submit a corrective action plan. If the corrective action plan is approved, the suspension is automatically lifted at the end of the 60-day period; indicates substantial deficiencies.
- 90-day suspension – Indicates serious and widespread deficiencies; the 90-day suspension of new referrals will only be lifted after an accepted corrective action plan is received. In addition, an acceptable follow-up review visit will be conducted if warranted.

- Termination – Indicates very serious and widespread deficiencies, generally coupled with a history of bad reviews. Termination is a last resort.

We have developed a system to score reviews based on the percentage of the identified deficiency and number of participants surveyed. Following is an outline of how reviews will be scored:

Calculating process

- The level of sanction will be decided based on the total score of the provider’s current review and the provider’s review history, which is converted from the deficiency percentage.
- Every 5% deficiency counts for 1 point in each class; the total score comes from the total points from each level.
- Since each level has different severity, multiple points will be added on each class’s score. Final score = level 3 = unweighted points x 3 + level 2 = unweighted basic points x 2+ level 1 = unweighted points x 1

Example:

<u>Level</u>	<u>Deficiency percentage</u>	<u>Basic points</u>	<u>Final points</u>
<u>Level 1 (less serious)</u>	<u>28%</u>	<u>5</u>	<u>5x1=5</u>
<u>Level 2 (serious)</u>	<u>20%</u>	<u>4</u>	<u>4x2=8</u>
<u>Level3 (major)</u>	<u>35%</u>	<u>7</u>	<u>7x3=21</u>
<u>Final score</u>			<u>34</u>

Based on the total score a sanction level is determined. If a provider has no deficiencies, they will not be subject to a sanction. Below is a chart that illustrates the sanction that will be imposed based on the final review score:

Score scale & Sanction Level

<u>Sanction Type</u>	<u>Final score</u>	<u>With Good History*</u>
<u>Correction Plans</u>	<u>0-99</u>	<u>0-149</u>
<u>30 Days Suspension</u>	<u>100-199</u>	<u>150-249</u>
<u>60 Days Suspension</u>	<u>200-299</u>	<u>250-349</u>
<u>90 Days Suspension</u>	<u>300-399</u>	<u>350-449</u>
<u>Termination</u>	<u>>400</u>	<u>>450</u>

Good History is determined based on previous review scores. For example, if a provider’s previous review had a total score of **50** and their current review has a score of **120**, the sanction for the current review will be corrective action rather than 30-day suspension based on the previous review score.

Scores are automatically calculated using a computer generated compliance review program.

Provider records will be reviewed periodically at the provider's office. Onsite visits are unannounced. If the reviewer arrives at the provider's office to conduct a survey and no one is there, the following sanctions will be imposed:

- First time – thirty (30) day suspension of new referrals
- Second time – ninety (90) day suspension of new referrals
- Third time – contract termination.

G. Administrative Requirements

1. The provider must inform CLTC of the provider's organizational structure, including the provider personnel with authority and responsibility for employing qualified personnel, ensuring adequate staff education, in-service training, and employee evaluations. The provider shall notify SCDHHS within three (3) working days in the event of a change in or the extended absence of the personnel with the above listed authority
2. The provider must provide SCDHHS a written document showing the organization administrative control and lines of authority for the delegation of responsibility down to the hands-on participant care level staff at contract implementation. The document should include an organizational chart including names of those currently in the positions. Revisions or modifications to this organizational document must be provided to SCDHHS. It is recommended that this document be readily accessible to all staff.
3. Administrative and supervisory functions shall not be delegated to another organization.
4. The provider shall acquire and maintain for the duration of the contract liability insurance and workers' compensation insurance as provided in Article IX, Section D of the Contract. The provider is required to list SCDHHS – CLTC as a Certificate Holder for informational purposes only on all insurance policies using the following address: Post Office Box 8206, Columbia, SC 29202-8206.
5. The provider will develop and maintain a Policy and Procedure Manual that describes how activities will be performed in accordance with the terms of the requirements of the contract. The Policy and Procedure Manual shall be available during office hours for the guidance of the governing body, personnel and will be made available to SCDHHS upon request.

6. The provider must comply with Article IX, Section Z of the Contract regarding safety precautions. The provider must also have an on-going program to prevent the spread of infectious diseases among its employees.
7. The provider agency shall ensure that key agency staff is accessible in person, by telephone, or by beeper during compliance review audits conducted by SCDHHS.
8. The provider will ensure that its office is open and staffed by qualified personnel during the hours of 10:00 am to 4:00 pm, Monday through Friday. Outside of these hours the Provider agency must be available by telephone during normal business hours 8:30 am to 5:00 pm, Monday through Friday. Failure to maintain an open and staffed office as indicated will result in sanctions as outlined in section F, last paragraph. The provider must also have a number for emergencies outside of normal business hours. Participant and personnel records must be maintained at the address indicated in the contract and must be made available, upon request, for review by SCDHHS.
9. The provider shall provide CLTC a list of regularly scheduled holidays for the coming year each September. The provider is not required to furnish services on those days.

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