

APPENDIX A-
MEDICAID HOME AND COMMUNITY-BASED WAIVER
SCOPE OF SERVICES
FOR
PERSONAL CARE I (PC I) SERVICES

A. Objectives

The objectives of PC I Services are to preserve a safe and sanitary home environment, assist participants with home care management duties and to provide needed supervision of Medicaid Home and Community-Based waiver participants.

B. Conditions of Participation

1. Agencies desiring to be a provider of PC I services must have demonstrated experience in providing home care management.
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 utilize the automated systems mandated by CLTC to document and bill for the provision of services.
5. Providers must accept or decline referrals from South Carolina Department of Health and Human Services (SCDHHS) or SCDDSN within two (2) working days. Failure to respond will result in the loss of the referral.
6. The provider must verify the participant's Medicaid eligibility when it accepts 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.
7. 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 for shopping, laundry services, other off-site services or escort services. The amount of time authorized does not include the aide's transportation time to and from the participant's residence.
2. The number of units and services provided to each participant are determined by the individual participant's needs as set forth in the participant's Service Plan/Authorization.
3. Under no circumstances will a PCI furnish any type of skilled medical service.
4. Services to be provided include:
 - a. meal planning and preparation
cleaning
laundry
shopping
home safety
errands
escort services
 - b. Limited assistance with financial matters, such as delivering payments to designated recipients on behalf of the participant. Receipts for payment should be returned to the participant.
 - c. Assistance with communication which includes, but is not limited to, placing phone within participant's reach and physically assisting participant with use of the phone, and orientation to daily events.
 - d. Observing and reporting on participant's condition.

D. Staffing

The provider must maintain individual records for all employees.

The provider must maintain all of the following (supervisory positions can be sub-contracted):

1. A supervisor who meets the following requirements:
 - a. High school diploma or equivalent;

- b. Capable of evaluating aides in terms of their ability to carry out assigned duties and their ability to relate to the participant;
- c. Able to assume responsibility for in-service training for aides by individual instruction, group meetings, or workshops;
2. Aides who meet the following minimum qualifications:
- a. Able to read, write and communicate effectively with participant and supervisor.
- b. Able to use the Care Call IVR system.
- c. Capable of following a care plan with minimal supervision.
- d. Be at least 18 years of age.
- e. Have documented record of having completed six (6) hours of training in the areas indicated in Section D.2.f, prior to providing services or documentation of personal, volunteer or paid experience in the care of adults, families and/or the disabled, home management, household duties, preparation of food, and be able to communicate observations verbally and in writing;
- f. Complete at least six (6) hours 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. Providing care including individual safety, laundry, meal planning, preparation and serving, and household management;
 4. First aid;
 5. Ethics and interpersonal relationships;
 6. Documenting services provided;
 7. Home support, e.g.
 - cleaning
 - laundry
 - shopping

- home safety
- errands
- observing and reporting the participant's condition

The annual six (6) hour requirement will be on a pro-rated basis during the aide's first year of employment.

3. 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:
 - a. The spouse of a Medicaid participant;
 - b. A parent of a minor Medicaid participant;
 - c. A step parent of a minor Medicaid participant;
 - d. A foster parent of a minor Medicaid participant;
 - e. Any other legally responsible guardian of a Medicaid participant.

Family members who are primary caregivers will not be reimbursed for HASCI respite services. All other qualified family members can be reimbursed for their provision of PCI services.

4. PPD Tuberculin Test

Please refer to Department of Health and Environmental Control (DHEC) website, Regulation 61-75 – Standards for Licensing page 11 of 36 section b. 1-6 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.

5. A criminal background check is required for all potential employees to include employees who will provide direct care to SCDHHS/SCDDSN participants and all administrative/office employees (office employees required to have background checks include: administrator, office manager, nurse 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 specific time period such as seven or ten year searches 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 to SCDHHS/SCDDSN 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 SCDHHS/SCDDSN participants under the following circumstances:

- Notification of participant/responsible party of aide's criminal background
- Provider must obtain a written statement, signed by the participant/responsible party acknowledging awareness of the aide's criminal background and agreement to have the aide provide care; this statement must be placed in the participant record.

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

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

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/Authorization from the Case Manager/Service Coordinator 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 SCDHHS (CLTC) Service Plan/SCDDSN 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 amount, frequency or duration. The provider must adhere to those duties which are specified in the SCDHHS (CLTC) Service Plan/SCDDSN Authorization in developing the Provider task list. This provider task list must be developed by the supervisor. If the provider identifies PC I duties that would be beneficial to the participant's care but are not specified in the SCDHHS (CLTC) Service Plan/SCDDSN Authorization, the Provider must contact the Case Manager/Service Coordinator to discuss the possibility of having these duties included in the SCDHHS (CLTC) Service Plan/SCDDSN Authorization. **Under no circumstances will any type of skilled medical service be performed by an aide.** The Case Manager/Service Coordinator will make the decision as to whether the SCDHHS (CLTC) Service Plan/SCDDSN Authorization should be amended to include the additional duty. This documentation will be maintained in the participant files.

2. As part of the conduct of service, the supervisor of PC I services must:

- a. Provide an initial visit prior to the start of PC I services for the purpose of reviewing SCDHHS CLTC plan of care, developing a task list for the aide, **(this task list must be developed prior to the provision of any PC I services)**, giving the participant written information regarding advanced directives and informing participants of their right to complain about the quality of PC I services provided. The supervisor must give participants information about how to register a complaint. Complaints against aides must be investigated by the Provider and appropriate action taken. Documentation must be maintained in the participant and the aide's file.
- b. Provide on-site supervision at least once every 365 days for each participant and phone and/or on-site contact with the participant at least once every 120 days. Supervisors must make phone contacts or conduct on-site supervision more frequently if warranted by complaints or indications of substandard performance by the aide.
- c. Each supervisory visit, including the initial visit, must be documented in the participant's file and recorded in Care Call. The Supervisor's report of the on-site visits must include, at a minimum:
 1. Documentation that services are being delivered consistent with the SCDHHS CLTC Service Plan/SCDDSN 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;
 - A brief statement regarding any changes in the participant's service needs; and
 - Supervisor's original signature and date. Rubber signature stamps are not acceptable.

Documentation of all supervisory visits must be filed in the participant's record within thirty (30) days of the date of the visit.
- d. Supervisors must provide assistance to aides as necessary.
- e. Supervisors must be accessible by phone and/or beeper during any hours services are being provided under this contract. If the PC I supervisory position becomes vacant, SCDHHS must be notified no later than the next business day.

- f. If there is a break in service which lasts more than sixty (60) days, the supervisor will be required to complete a new initial visit.
5. In addition, the provider must maintain an individual participant record that documents the following items:
- a. Initiation of PC I services on the date negotiated with the Case Manager/Service Coordinator and indicated on the Medicaid Home and Community-Based waiver authorization. Services must not be provided prior to the authorized start date and must be provided according to the schedule as indicated on the SCDHHS CLTC Service Plan/SCDDSN Authorization.
 - b. Notification to the Case Manager/Service Coordinator within two (2) working days of the following participant changes:
 1. Participant's condition has changed and the SCDHHS CLTC Service Plan/SCDDSN Authorization no longer meets participant's needs or the participant no longer appears to need PC I services.
 2. Participant dies, is institutionalized or moves out of the service area.
 3. Participant no longer wishes to participate in a program of PC I services.
 4. Knowledge of the participant's Medicaid ineligibility or potential ineligibility.
 - c. The provider will maintain a record keeping system that documents:
 1. **For SCDHHS participants:** The delivery of services in accordance with the SCDHHS CLTC 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 file within thirty (30) days of service delivery.
 2. **For SCDDSN participants:** The delivery of services and units provided in accordance with the service authorization. The provider will maintain daily logs reflecting the PCI services provided by the aides for the participants and the actual

amount of time expended for the service. The daily logs must be initialed daily by the participant/family member and the aide, and must be signed weekly by the participant/family member and signed, with original signature (rubber signature stamps are not acceptable), and dated by the Supervisor at least once every two weeks. Daily logs must be filed in the participant's file within thirty (30) days of service delivery.

All documentation must be made available to SCDHHS/SCDDSN upon request.

- d. **For SCDHHS participants only:** For all instances in which a participant did not receive an authorized daily service, providers must indicate on the Care Call web site the reason why the service was not delivered. The provider must do this both when the provider was unable to complete the visit and when the participant was not available to receive the visit. For each week in which there are missed visits, the provider must indicate the reason on the web site by the close of business the following week. A missed visit report is not required for SCDDSN participants.
- e. Whenever two consecutive attempted visits occur, the local SCDHHS/SCDDSN office must be notified. An attempted visit is when the aide arrives at the home and is unable to provide the assigned tasks because the participant is not at home or refuses services.

F. Overview of 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.

Following is a chart that 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	
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.

F. Administrative Requirements

1. The provider must inform SCDHHS 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 with 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 worker's 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 infectious disease program to prevent the spread of infectious diseases among its employees.

7. The provider agency shall ensure that key agency staff are accessible in person, by telephone, or by beeper during compliance review audits conducted by SCDHHS and/or its agents.
8. The provider will ensure that its office is 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 SCDHHS a list of regularly scheduled holidays for the coming calendar year each September. The provider is not required to furnish services on those days. The PC I provider agency may not be closed for more than two (2) consecutive days except when a holiday falls in conjunction with a weekend. If a holiday falls in conjunction with a weekend, a PC I provider agency may be closed for not more than four (4) consecutive days.
10. The provider must have an effective written back-up service provision plan in place to ensure that the participant receives the PC I services as authorized. Whenever the provider determines that services cannot be provided as authorized, the Case Manager/Service Coordinator must be notified by telephone immediately.

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