LONG TERM HOME HEALTH CARE PROGRAM WAIVER
CMS QUALITY ASSURANCES

CMS QUALITY ASSURANCE	LDSS RESPONSIBILITIES	LTHHCP AGENCY RESPONSIBILITIES
I. The waiver must have an adequate and effective system to assure appropriate level of care determinations with ongoing, systemic oversight of the level of care determination process. • **An evaluation for level of care must be provided to all applicants for whom there is reasonable indication services may be needed in the future.** • **The level of care of enrolled participants must be reevaluated as frequently as specified in the approved waiver.** • **The process and instruments used to determine participant level of care must be applied appropriately and according to the description in the approved waiver application.**	The LDSS must: • Assure each applicant for whom there is reasonable indication services may be needed has had his/her need for nursing home level of care (LOC) assessed and, if accepted into the waiver, has that LOC reassessed at least every 180 days or more frequently if circumstances warrant. • Obtain physician's recommendation and level of care assessment (DMS-1) from the LTHHCP agency. • Review every LOC instrument, i.e., The Long Term Care Placement Form, Medical Assessment Abstract (DMS-1) submitted and completed by the licensed medical professional assessor to assure all sections are complete, the form is signed and dated appropriately, and all indicators are scored accurately. • Confer with the assessor to discuss and remediate all identified issues. • If agreement can not be reached, request review by the LDSS local professional director who will review the case and make the LOC determination. • Contact State waiver management staff for technical assistance if needed in resolving disputes.	The LTHHCP agency must: • Have staff RN examine /interview /assess an applicant/participant in a face to face visit to complete the Long Term Care Placement Form, Medical Assessment Abstract (DMS-1) and sign it, attesting to the validity of the assessment. (Alternatively, this may be done by the applicant/participant's attending physician or a facility RN if the individual is hospitalized or residing in a nursing home.) • Forward the assessment to the LDSS in a timely manner and confer with the LDSS to discuss and remediate all identified issues, accepting the determination of the LDSS local professional director if agreement can not be reached with LDSS staff.

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	• Track and report timeliness of application processing information related to LOC assessments/determinations, using specifications provided by DOH.	
II. The waiver must maintain an effective system for reviewing the adequacy of service plans for waiver participants. • **Service plans must address all participants' assessed needs (including health and safety risk factors) and personal goals, either by waiver services or other means.** • **Service plan development must be monitored in accordance with policies and procedures.** • **Service plans must be updated/revised as set forth in the waiver application but, at minimum, at least annually or when warranted by changes in the participant's needs.** • **Services must be delivered in accordance with the service plan, including the type, scope, amount and frequency specified in the service plan.** • **Participants must be afforded choice between waiver services**	The LDSS must: **Plan of Care Development** • Authorize initial home assessment. • Conduct an assessment of the home environment, the individual's psychosocial status and availability of support systems using the Home Assessment Abstract (HAA) tool which is used with the DMS-1/PPRI to provide a full assessment of the individual's strengths and needs. This is done in cooperation with the LTHHCP agency. • Use the full assessment to develop a Plan of Care which includes the range of services, both waiver and non-waiver, necessary to allow the individual to remain in the community, addressing his/her health, welfare and personal goals. This is done with the LTHHCP. • Identify risk factors and safety considerations; incorporating interventions into the Plan of Care with consideration of the participant's assessed preferences. • Include necessary back-up arrangements such as availability and use of family members or other informal supports to assist the participant.	The LTHHCP agency must: **Plan of Care Development** • Conduct a DMS-1 assessment or obtain one from the medical professional who conducted the assessment (as noted above under the first assurance) to be used with the HAA tool completed with the LDSS to provide a full assessment of the individual's strengths and needs. • Use the full assessment to develop a Plan of Care which includes the range of services, both waiver and non-waiver, necessary to allow the individual to remain in the community, addressing his/her health, welfare and personal goals. This is done with the LDSS. • Identify risk factors and safety considerations, incorporating interventions into the Plan of Care with consideration of the participant's assessed preferences. • Include necessary back-up arrangements such as availability and use of family members or other informal supports to assist the

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and institutional care and between/among waiver services and providers. **Note: Federal Medicaid waiver terminology uses "service plan;" in the LTHHCP waiver this is referred to as the "plan of care."**	• Include the applicant/participant, his/her family, significant others, legally designated representative(s) and/or other representatives of his/her choosing in Plan of Care development. • Maintains a positive relationship with the individual and family by clearly identifying the names and telephone numbers and by explaining the responsibility of the LDSS personnel who will be contacting the individual and supporting the family's involvement in the program. • If disagreements occur in Plan of Care development, confer with the LTHHCP agency for remediation; if agreement can not be reached refer the case for review to the local professional director who will determine appropriate adjustments. • Review the proposed Plan of Care and compare it to the physician's orders to ensure all needs are met and services provided. • Investigate all unmet needs and, if found, contact the LTHHCP agency for discussion and resolution. • Develop the individual's budget based on the agreed upon the Summary of Service Requirements; annualize the individual's budget, as appropriate, to effectively address fluctuations in his/her service needs. Gives final approval on budgets proposed by the LTHHCP provider.	participant. • Include the applicant/participant, his/her family, significant others, legally designated representative(s) and/or other representatives of his/her choosing in significant others in Plan of Care development. • Maintains good working relationships with the family and other caregivers. Notifies LDSS of any changes in family or caregiver support. • If disagreements occur in Plan of Care development, confer with the LDSS for remediation; if agreement can not be reached, comply with decisions of the local professional director who determines appropriate adjustments. • Assist LDSS staff in determining necessary services and costs. May propose budget for individual for LDSS approval. • Discuss and resolve with the LDSS any findings regarding unmet needs. • Assist LDSS in referring ineligible individuals to alternate services. • Provide all applicants approved for waiver participation with a copy of the bill of patient's rights, documenting in the clinical record that this has been given to the participant.

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	• Maintains and authorizes use of "paper credits" for individual. • Approve for waiver participation each individual whose needs, goals, health and welfare can be served within his/her individual limit. Authorize provision of LTHHCP services and participation; and notify provider concerning admission dates. • Assure the individual is referred to other appropriate resources if the Plan of Care can not meet the individual's needs to assure health and safety.	
	Plan of Care Update/Revision • Repeat the Plan of Care process at least every 180 days or more frequently when circumstances warrant. Review all subsequent Plans of Care for completeness and timeliness. • Approve of any change in the Summary of Service Requirements arising from changes in the individual's health status, and agree or disagree with any proposed changes to the services specified in the Plan of Care. • Use the range of available options to continue to meet the individual's service needs, e.g. use of paper credits, budget annualization, use of appropriate alternative waiver/non-waiver services, maximization of third party resources, increased use of informal supports, including other community resources. Also,	**Plan of Care Update/Revision** • Repeat the Plan of Care process at least every 180 days or more frequently when circumstances warrant. • In accordance with Medicare Conditions of Participation, review the Plan of Care at least every 60 days or more frequently when there is a significant change in the individual's condition and promptly alert the physician of any need to alter services requiring the physician's order. • Use the range of available options to continue to meet the individual's service needs, e.g. use of paper credits, budget annualization, use of appropriate alternative waiver/non-

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	coordinate (with provider RN) any changes in services with the family/caregivers to help them understand the changes. • Seek appropriate alternatives when decreasing services or referring to alternative community based services or for institutionalization; provide comprehensive information to any agency to which individual referred. • Send notice to the individual/family regarding: proposed discontinuance of the individual's participation in the LTHHCP; proposed reduction, denial, discontinuance of service contrary to treating physician orders or when level of budget cap changes from SNF to HRF.	waiver services, maximization of third party resources, increased use of informal supports, including other community resources. Also, coordinate (with the LDSS representative) any changes in services with the family/caregivers to help them understand the changes. • Notify LDSS concerning hospital admissions and other changes in status that might indicate the need for discharge from the LTHHCP. • Seek appropriate alternatives when decreasing services or referring to alternative community based services or for institutionalization; provide comprehensive information to any agency to which individual referred
	Service Delivery • Assist LTHHCP provider in arranging for delivery of services not available from the LTHHCP (adult protection, legal counseling, recreational therapy, financial counseling, friendly visitors and/or telephone reassurance) as well as in making referrals to LDSS programs (such as Food Stamps, HJEP, and PA). • Maintain regular contact with the waiver participant to discuss the delivery of services in the approved initial or revised Plan of Care.	**Service Delivery** • Implement and oversee the Plan of Care, coordinating and monitoring the provision of LTHHCP services. With the LDSS representative) arranges for the non-LTHHCP services. • Conduct aide supervision as required by applicable regulations. • Address with the LDSS any issues identified during LDSS home visits.

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	Participant Choice • Offer all potential waiver participants informed choice between community-based services and institutional care. • For those choosing community-based care, discuss and offer choice of MA waiver programs and non-waiver services/programs such as the Personal Care Services Program or Managed Long Term Care. • Notify all potential individuals or their families about availability of LTHHCP services (verbal and written notification). • Offer choice of providers of such services/programs from among qualified/participating providers. • Provide applicants/participants with the *LTHHCP Consumer Information Packet*, customized to include a list of LTHHCP agencies serving the county.	**Participant Choice** • When "alternate entry" is initiated for an individual: (a) offer all potential waiver participants informed choice between community-based services and institutional care; and (b) for those choosing community-based care, discuss and offer choice of MA waiver programs and non-waiver services/programs such as the Personal Care Services Program or Managed Long Term Care • Offer choice of waiver services providers from among qualified/participating providers. The applicant/participant has the right to choose from among the available providers.
III. The waiver must have an adequate system for assuring all waiver services are provided by qualified providers. • **All providers must initially and continually meet required licensure and/or certification standards and adhere to other state standards prior to furnishing waiver services.**	The LDSS must: • Use only those agencies certified by DOH and approved for enrollment in eMedNY as the applicant's/participant's LTHHCP agency. • Participate in provider training and technical assistance opportunities at the request of DOH. • Contact DOH and/or call the Home Health Hotline if there is a concern related to the	The LTHHCP agency must: • Remain in compliance with all federal and State certification and survey requirements, including: - orientation and ongoing training of staff and an annual performance evaluation which includes an in home visit to observe interaction with participants; - maintenance of appropriate

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• **All non-licensed providers/non-certified providers must be monitored to assure adherence to waiver requirements.** • **Provider training must be conducted in accordance with state requirements and the approved waiver.**	quality of services provided by the LTHHCP agency and the agency is not remediating the problem.	contracting policies and procedures to fulfill the LTHHCP agency's responsibility for assuring all contracted staff are appropriately licensed, certified and in compliance with established qualifications for providing LTHHCP services; - maintenance of an agency quality management process which includes an annual overall evaluation of its total program by professional personnel. • Comply with applicable State fingerprinting requirements for prospective employees. • Enroll in eMedNY, submitting and annually updating all required certification statements. • Participate in provider training and technical assistance opportunities at the request of the LDSS or DOH.
IV. The waiver must have an adequate system for identifying, addressing and preventing instances of abuse, neglect and exploitation. • **Abuse, neglect and exploitation must be identified, addressed and prevented on an ongoing basis.**	The LDSS must: • Monitor the health and welfare of individual participants. • Assure staffs involved with assessment, reassessment and service delivery or oversight under the waiver comply with all NYS requirements for reporting abuse and/or neglect applicable to their professional status.	The LTHHCP agency must: • Monitor the health and welfare of individual participants. • Assure staffs involved with assessment, reassessment and service delivery or oversight under the waiver comply with all NYS requirements for reporting abuse

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	• Refer cases as appropriate to the LDSS' Protective Services for Adults or Child Protective Services programs; document such referrals in the case record; and, work with those programs as appropriate on resolution of issues. • Monitor follow-up activity to assure corrective action. • Comply with DOH reporting specifications regarding identification of significant occurrences of abuse, neglect and/or exploitation and corrective actions. • As provided in for in the *Consumer Information Booklet*, provide participants with the DOH Home Health Hotline phone number.	and/or neglect applicable to their professional status. • Comply with federal and State requirements for policies and procedures which support the prevention, identification and/or remediation of abuse, neglect and exploitation, e.g. requirements for agency quality management processes to report adverse incidents/outcomes for investigation, action and quality improvement. • Refer cases as appropriate to the LDSS' Protective Services for Adults or Child Protective Services programs; document such referrals in the case record; and, work with those programs as appropriate on resolution of issues. • Provide participants with the DOH Home Health Hotline phone number
V. The State must retain ultimate administrative authority over the waiver and administration must be consistent with the approved waiver application. • **The State Medicaid agency must retain ultimate administrative authority by exercising oversight of the performance of waiver functions by other State and local/regional non-State**	The LDSS must: • Participate as requested by DOH in State waiver management staff review of case records, including completion of any self-assessments required prior to State on-site review and implementation of any identified corrective actions. • Participate as requested by DOH in quarterly technical assistance advisory calls and/or other training activities.	The LTHHCP agency must: • Participate as requested by the LDSS and DOH in State waiver management staff review of case records, including completion of any self-assessments required prior to State on-site review and implementation of any identified corrective actions. • Comply with all State survey requirements, including

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agencies and contracted entities.	• Maintain accurate and complete case documentation and comply with all DOH specified tracking/reporting requirements.	implementation of any corrective actions that must be implemented pertaining to the assurances, e.g. LOC assessments/determinations. For LTHHCPs which are Certified Home Health Agencies, these surveys serve as a primary mechanism for the State to assure that the agencies are complying with all Medicare Conditions of Participation pertaining to the assurances, e.g. components of plan of care development. • Participate as requested by the LDSS and/or DOH in technical assistance advisory calls and/or other training activities. • Maintain accurate and complete case documentation and comply with all tracking/reporting requirements specified by the LDSS and/or DOH.
VI. The waiver must maintain an adequate system for assuring financial accountability. • **Claims must be coded and paid for in accordance with reimbursement methodologies specified in approved waiver application.**	The LDSS must: • Compute each individual's monthly MA expenditures based upon the Summary of Services Requirements and assure expenditures will be within the approved monthly budget cap before authorizing the individual's participation in the waiver. • Give final approval on budgets proposed by LTHHCP provider. Maintain and authorize use of "paper credits" for participants.	The LTHHCP agency must: • Notify LDSS on the first working day following the noting of a change in an individual's condition and concerning any changes in the authorized Summary of Service Requirements. • Seek prior authorization for any service change that exceeds the spending cap for the individual by 10% or more when the level of service changes from SNF to HRF.

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	• Review the participant's Plan of Care and monitor expenditures at least every 180 days as part of the reassessment process. • Incorporate any changes in the Summary of Service Requirements into monthly budget and adjust paper credits. Authorize any changes that exceed the approved budget by more than 10%. • Identify an approved participant's authorization for the waiver by entering Code 30 in the Welfare Management System's Restriction/Exception Code. • When authorizing State Plan services for an applicant/participant such as PERS, assure that those services are not duplicated within the waiver Plan of Care. • Maintain necessary documentation and provide information requested by DOH and/or federal and State audit agencies necessary for program oversight.	• Comply with eMedNY enrollment and billing requirements. • Bill Medicare and third-party insurance for services, when appropriate, prior to billing Medicaid. Inform LDSS of any third-party insurance coverage. • Submit claims only for individuals who have been authorized by the LDSS as LTHHCP participants. • Secure an independent audit of their financial statements attesting to the accuracy of their annual cost report submitted to DOH. • Maintain necessary documentation and provide information requested by DOH and/or federal and State audit agencies necessary for program oversight.