

MEDICAID HOME AGAIN PROGRAM

SCOPE OF SERVICE FOR TRANSITION COORDINATION SERVICE

A. Objective

The objective of Transition Coordination is to provide assistance with the transition process to Home Again participants. The Transition Coordination service will support the participants in order to make a successful transition into the community. The Transition Coordination service will also ensure continued access to appropriate and available services for participants to remain in the community.

B. Conditions of Participation

1. The Provider and provider staff delivering Transition Coordination Service must be one of the following: Licensed Baccalaureate Social Worker (LBSW), Licensed Master Social Worker (LMSW), Case Manager Certified (CMC), Registered Nurse (RN), or individuals with a Bachelor's degree in a health or human services field from an accredited college or university.
2. The license and certification must be in the state of South Carolina and in good standing, if applicable.
3. The Provider must have demonstrated at least two (2) years of case management experience with one of the Home Again target populations; either older adults or people with physical disabilities.
4. The Provider must be able to provide the specified geographical area (counties) in which they will deliver the Transition Coordination service. Transition Coordinators servicing multiple area offices must designate a CLTC office for training and meetings.
5. The Provider will be responsible for provision of all supplies and tools necessary to carry out Transition Coordinator functions. The Provider will be responsible for assuring each Transition Coordinator has a laptop computer meeting South Carolina Department of Health and Human Services (SCDHHS) specifications.
6. The Provider will ensure that Transition Coordinator does not service members of his/her own immediate family.
7. The Provider should be available by telephone to participants and SCDHHS staff Monday through Friday, 8:30 A.M. to 5:00 P.M., and, if there is other employment, it shall not prevent the Transition Coordinator from performing

Transition Coordination during these hours. The Provider will guarantee accessibility to participants and the program staff.

8. The Provider must also be available to meet with SCDHHS staff by either face-to-face or by phone.
9. The Provider must check voice mail at least twice daily Monday-Friday, excluding state holidays.
10. The Provider must sync with the Phoenix System prior to any field activity to verify services and daily if any work has been performed.
11. The Provider is responsible for secure and accurate maintenance of all participant records.
12. The Provider must scan into Phoenix all consumer specific documents received from outside sources. All hardcopy records shall remain in the participant's assigned Area Office.
13. The Provider must check and respond to e-mails daily, Monday-Friday.
14. The Provider must return calls related to participant care within 24 hours.
15. The Provider will ensure that each Transition Coordinator utilizes the Care Call System. Care Call documentation must be completed upon each transition coordination visit and transition coordination contact. For home visits, the call to the Care Call System must be completed while in the Participant's home.
16. The Provider will ensure that each Transition Coordinator providing Transition Coordination services uses the Phoenix System to document all Transition Coordination activities, as specified in Section G.
17. The Provider must complete documentation in the Phoenix System within 48 hours after the visit and contact.
18. The Provider will ensure that each Transition Coordinator meets the Training Requirements set out in Article F of this document.

C. Description of Services to be Provided

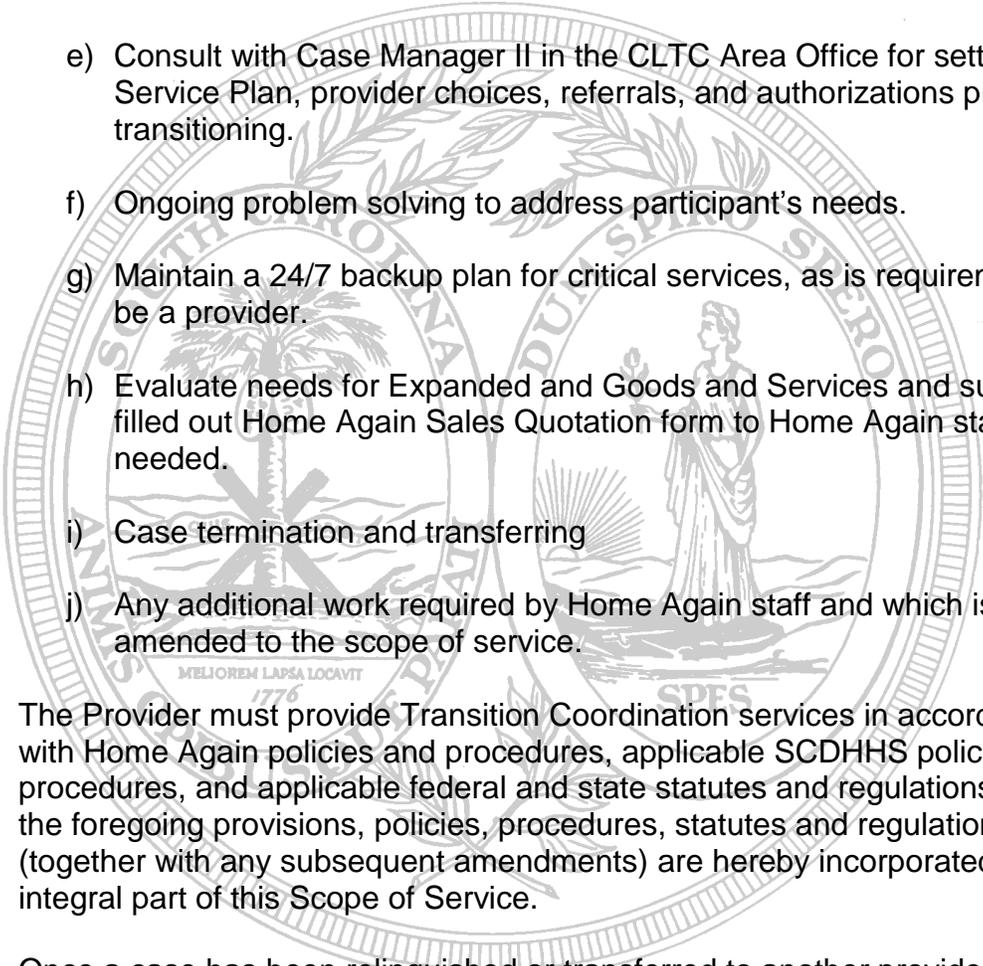
1. The Provider must use the Phoenix System to enter a list of regularly scheduled holidays; the Provider shall not be required to furnish services on those days. The Provider must not be closed for more than two consecutive days at a time, except when a holiday falls in conjunction with a weekend. If

a holiday falls in conjunction with a weekend, the Provider may be closed for not more than four consecutive days.

2. The Provider must make provisions for coverage during times when the Provider is unavailable. Providers must have an office location.
3. Transition Coordination services must be performed as set forth in the CLTC Area Office Home Again Policy.
4. The Transition Coordinator must use professional judgment in allotting a sufficient amount of time to complete activities, including all visits and contacts. Following is the minimum visit and contact schedule that the Provider must conduct:
 - a) Pre-transition planning: The Provider must complete an initial visit to the potential participant in a skilled nursing facility. A home visit is also required once housing is identified in the community.
 - b) The Provider must be present either at the facility or at home in the community on the transition date.
 - c) During the first two (2) months, there must be two (2) face-to-face visits and two (2) telephone calls per month.
 - d) During months 3-12, the Providers will perform one (1) face-to-face visit every other month and one (1) monthly telephone call.
 - e) Additional visits and contact may be required as needed or if the transition is in jeopardy. If Care Call reflects that the amount of time spent to complete the billed activities for a particular day does not meet Home Again staff's expectations of the time necessary to complete those activities, then at SCDHHS' sole discretion, Home Again staff may conduct an investigation and may recoup payments for those activities from the Provider.

D. Transition Coordination

1. Cases will be assigned in accordance with the Participant's choice.
2. Provider must notify SCDHHS within two (2) working days of its intent to accept or decline a referral for Participant service.
3. The Transition Coordination service includes the following but is not limited to:
 - a) Initial visit to a skill nursing facility and a home in the community to determine transition possibility.

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- b) Conducting comprehensive assessment to identify the participant's needs.
 - c) Developing and monitoring transition plan with a participant and assist the transition process.
 - d) Assist the participant with housing needs and ensure that the participant is moving into a qualified "Home and Community based residence."
 - e) Consult with Case Manager II in the CLTC Area Office for setting up Service Plan, provider choices, referrals, and authorizations prior to the transitioning.
 - f) Ongoing problem solving to address participant's needs.
 - g) Maintain a 24/7 backup plan for critical services, as is requirement to be a provider.
 - h) Evaluate needs for Expanded and Goods and Services and submit filled out Home Again Sales Quotation form to Home Again staff, if needed.
 - i) Case termination and transferring
 - j) Any additional work required by Home Again staff and which is amended to the scope of service.
4. The Provider must provide Transition Coordination services in accordance with Home Again policies and procedures, applicable SCDHHS policies and procedures, and applicable federal and state statutes and regulations. All of the foregoing provisions, policies, procedures, statutes and regulations (together with any subsequent amendments) are hereby incorporated as an integral part of this Scope of Service.
5. Once a case has been relinquished or transferred to another provider, Provider must cease any contact with the Participant and/or primary contact.

E. Staffing – Provider must adhere to the following provisions related to staffing

- 1. Transition Coordinators cannot simultaneously be working as a Medicaid Waiver Case Manager with the same participant.
- 2. Transition Coordinators must have a current valid driver's license.

3. When servicing Participants, Transition Coordinators must display a picture identification badge identifying agency/organization or independent status.
4. Transition Coordinators must comply with the continuing education requirements necessary for their licensure/certificate.
5. Transition Coordinators must have demonstrated skills in computer hardware/software access and usage.
6. Transition Coordinators must agree to accept a minimum of one (1) case and cannot carry a caseload of over fifteen (15) cases at the same time without the approval of the Home Again staff.
7. PPD Tuberculin Test

The Provider must comply with the PPD Tuberculin test requirements found on the Department of Health and Environmental Control website, Regulation 61-75 Standards for Licensing at:

www.scdhec.gov/health/licen/hladcinfo.htm

If Provider requires additional information, Provider should contact the Tuberculosis Control Division, Department of Health and Environmental Control, 1751 Calhoun Street, Columbia, S.C. 29201 (telephone: (803) 898-0558).

8. Personnel folders: Individual records will be maintained to document that each member of the staff has met the above requirements.

F. Transition Coordination Training

1. Transition Coordinators must attend Medicaid sponsored Transition Coordination training, either in person or via online prior to be enrolled as the provider in Phoenix.
2. All new Transition Coordinators must meet or do conference call with Transition Coordination Manager prior to take the first case.

G. Transition Coordination Activities and Rates

1. The provider will be paid based on each milestone: a) pre-transition planning, b) transitioning, c) six month milestone from transition date, and d) one year milestone from transition date. See appendix A for the rates.

2. Providers have a responsibility to notify Home Again staff once each milestone has been met. The provider must complete the activities below in order to request the payments.

Pre-transition planning

- a) Make initial visit to a nursing facility to meet with the potential participant.
- b) Conduct the Risk Assessment to determine transition safety and possibility.
- c) Document all visits/contacts into Phoenix System.
- d) Conduct a visit to the participant's home in the community and determine home modification needs.
- e) Complete Quality of Life survey 3 weeks prior to transitioning.
- f) Discuss possible waiver services for the participant with CLTC Case Manager II in the Area Office and follow up on the case to make appropriate referrals and authorizations.
- g) Ensure participants recurring income is transferred from nursing facilities to the participants.
- h) Complete all pre-transition planning checklist up to "1-2 days prior to move" tab in Phoenix System.
- i) Make sure medications and/or prescriptions are acquired prior to the discharge date.

Note: The Provider will be paid \$200 if the transition is deemed unsafe and the case terminated.

Transitioning

- a) Be present at the nursing facility or at the participant's home on the transition date.
- b) Document all visits/contacts into Phoenix System.
- c) Explain to the participant all services the person will be receiving, including Home Again demonstration program, waiver services, and any additional community services.

- d) Ensure each waiver authorization has a service start date.
- e) Monitor if the necessary Home Modifications are completed and identify if house set up is completed.
- f) Complete activities on the “Day of Move” tab in Phoenix System.
- g) Report Home Again staff and make a narrative in Phoenix if any Critical Incident occurs. Critical Incidents include hospitalizations, deaths due to abuse/neglect, deaths, contact with the criminal justice System, and medication errors.

Six month milestone from transition date

- a) Comply with minimum visit/contact schedule as followed:
 - Month 1-2: two (2) face-to-face visits and two (2) telephone calls
 - Month 3-12: one (1) face-to-face visit every other month and one (1) telephone call each month
- b) Document all visits/contacts into Phoenix System.
- c) Complete activities on the “1st Week after Move” and “1st Month after Move” tabs in Phoenix System.
- d) Report Home Again staff and make a narrative in Phoenix if any Critical Incident occurs.

One year milestone from transition date

- a) Comply with visit/contact schedule, at least one face-to-face visit every other month and one (1) telephone call each month.
- b) Document all visits/contacts into Phoenix System.
- e) Complete activities on the “11 Months after Move” tab in Phoenix System.
- f) Conduct new Quality of Life survey in 11th month from the transition date.
- g) Follow case transferring policy and procedures after 365 days from the transition date.

- h) Report Home Again staff and make a narrative in Phoenix if any Critical Incident occurs.

H. Administrative Requirements

1. The Provider must maintain an up-to-date organizational chart that is available to each employee.
2. The Provider must maintain written bylaws (or the equivalent) for governing the Provider's operations.
3. The Provider must assure SCDHHS that a governing body or person(s) so functioning shall assume full legal authority for the operation of the provider agency.
4. The Provider shall acquire and maintain, during the life of the contract, general liability insurance and worker's compensation insurance. The Provider is required to list SCDHHS-Home Again as certificate holder for notice purposes on all insurance policies using the following address: Post Office Box 8206, Columbia, South Carolina, 29202-8206.
5. The Provider must have an effective written back-up service provision plan in place to ensure that the participant receives the Transition Coordination services. Whenever the Provider determines that services cannot be provided as authorized, the Provider shall immediately notify Home Again Transition Coordination Manager and the waiver Case Manager by telephone.
6. The Provider will be responsible for continuing Transition Coordination activity for all cases in the Provider's caseload. Should the Provider be unable to cover a case(s), the Provider shall immediately notify Transition Coordination Manager by telephone.
7. Upon request by SCDHHS, the Provider will be responsible for appropriate participation in the SCDHHS Appeals and Hearings process with respect to appeals of any action involving the Provider.
8. The Provider is subject to recoupment for payments made for services as a result of authorizations issued by provider staff not consistent with Home Again policies and procedures and in accordance with the Transition Coordination Scope of Service.
9. The Provider must disclose to SCDHHS the names and relationships of any relatives of the Provider or its staff who provide items or services to Medicaid Participants. For purposes of this Contract, the Provider means all owners, partners, managing employees, directors and any other person involved in the direct management and/or control of the business of the Provider. The

Provider's staff includes everyone who works for or with the Provider, including independent contractors, in the provision of or billing for services described in this Contract. Relative means persons connected to the Provider by blood or marriage.

The Provider must disclose all such relationships in writing to Home Again, SCDHHS, within two (2) days of learning of the relationship. The Provider, in executing this Contract, certifies that it has in place policies, procedures or other mechanisms acceptable to SCDHHS to identify and report these relationships.

Failure to report a relationship timely or to have the appropriate policies and procedures in place may result in sanctions by SCDHHS up to and including termination of this Contract for cause.

April 1, 2015



APPENDIX A

**TRANSITION COORDINATION RATES
EFFECTIVE JULY 1, 2014 - JUNE 30, 2015**

Provider shall be paid the following rates once all provider activities are completed, as described in Section G of the Transition Coordination Scope of Service, for the specified timeframe below:

| <u>Service(s)</u> | <u>Procedure Code(s)</u> | <u>Rate(s)</u> |
|-------------------------|--------------------------|-------------------------|
| Pre-Transition Planning | T2038 | \$500/Upon Completion |
| | T2024 | \$200/Upon Completion |
| At Transition | T2038 | 1,000/Upon Completion |
| Six Month Milestone | T2038 | \$500/Upon Completion |
| One Year Milestone | T2038 | \$1,000/Upon Completion |

