REGION IV

Area Agency on Aging, Inc.

SPECIALISTS IN AGING

DIRECT SERVICE PURCHASE

OPERATIONAL GUIDELINES AND PROCEDURES

Region IV Area Agency on Aging
2900 Lakeview Avenue
St. Joseph, MI 49085
Ph: 269.983.0177
Fax: 269.983.4028
Toll Free: 1-800-442-2803

Revised 12/06/2023.

The mission of the Area Agency on Aging (AAA) is to provide choices for independent lives. The AAA has served the community since 1973, and throughout its history, has developed, served, and coordinated community services on behalf of persons who are elderly or disabled and their families, and who reside in the southwest Michigan counties of Berrien, Cass, and Van Buren.

In order to be enrolled by the AAA as a network provider, community service providers agree to comply with the following Operational Guidelines and Procedures and applicable Service Standards:

Introduction

The Care Management (CM) program assists people whose care needs require a specialized management effort by locating, mobilizing, and managing necessary community-based services. All CM clientele may receive services regardless of race, color, religion, sex, sexual orientation, national origin or income, and are evaluated on an individual basis, with varying funding sources having differing requirements. During the initial call to the agency, clients are evaluated for needs, with program qualifications determined by care managers.

The program serves adults who are at risk of nursing home placement, functionally unable to provide self-care without assistance, and who may lack the support needed to meet their care needs, as well as persons with moderate impairments requiring support in the home setting. Many people served have multiple deficits in their ability to perform activities of daily living, such as bathing, grooming, and transferring due to illness or declining health, and may be physically frail to the extent that they meet medical admission criteria for nursing homes but choose to receive long-term care in the home. The inability of traditional health care systems to address these in-home care needs, and the corresponding burden placed on family and friend caregivers threatens continued independence.

Care Management nurse and social worker teams perform comprehensive assessments to identify care needs and then plan, access, monitor, reassess, provide social and emotional supports, advocate, and manage necessary services. Services may be paid for in a number of ways including Medicare, Medicaid, private insurance, community programs, or private pay. The care manager determines how services will be paid for, and clients pay what their finances allow. Many people served by Care Management receive services at no cost depending on individual circumstances.

Direct Service Purchase System

The Direct Service Purchase (DSP) provider pool is established through formal agreements with existing community providers. Services purchased are intended to meet identified needs and to bolster the ability of families to continue their caregiving activities. Specific Minimum Service Standards for both MI Choice Waiver/MDHHS and The Bureau of Aging, Community Living, and Supports (ACLS Bureau) are provided as part of the application process. Services available for bid, including a brief description and unit, include the following:

Adult Day Services - Services furnished either one-half day (2-5 hours) or a full day (6+ hours) on a regularly scheduled basis, for one or more days per week, or as specified in the service plan, in a non-institutional, community-based setting, encompassing both health and social services needed to ensure the optimal functioning of the individual.
Unit = ½ day or full day

Chore Services - Services needed to maintain the home in a clean, sanitary and safe environment, including heavy household chores such as washing floors, windows and walls; tacking down loose rugs and tiles; moving heavy items or furniture. This service also includes yard maintenance (mowing, raking, and clearing hazardous debris such as fallen branches and trees) and snow shoveling or plowing to provide safe access and egress outside of the home.
Unit = 15 minutes of service provided or one chore at accepted job bid.

Community Health Worker - The Community Health Worker (CHW) works with participants who are re-enrolling into a program or enrolling after a nursing facility or hospital discharge. The CHW also perform the duties of a supports broker with planning and implementing a service plan by assisting the participant in making informed decisions about what works best for the participant and by assisting the participant to explore and access community services.
Unit = 15 minutes of service provided or per service.

Community Living Supports (CLS) – Facilitation of an individual's independence and promotion of participation in the community, whether in the participant's residence or in community settings. Community Living Supports include assistance to enable program participants to accomplish tasks that they would normally do for themselves if able. Transportation, which is incidental to the provision of CLS, is included at a maximum of 15 miles per week.
Unit = 15 minutes of service provided (in-home); or per hour (residential).

Community Transportation - The Community Transportation (CT) service combines non-emergency medical transportation and non-medical transportation into one transportation service. Community Transportation (CT) services are offered to enable participants to access services, activities, and resources as specified in the individual plan of services. The CT service may also be utilized for expenses related to transportation and other related travel expenses determined necessary to secure medical examinations/appointments, documentation, or treatment for participants. Delivery services for medical items, such as medical supplies or prescriptions, should be utilized before authorizing CT services.
Unit=per trip, per mile, or per pass.

Counseling Services - Provision of professional level counseling services which seek to improve the individual's emotional and social well-being through the resolution of personal problems and/or change in a client's social situation.
Unit = One visit, regardless of duration.

Environmental Accessibility Adaptations – Those physical adaptations to the home, required by the participant's service plan, that are necessary to ensure the health and welfare of the participant or that enables the participant to function with greater independence in the home, without which, the participant would require institutionalization. Such adaptations include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies that are necessary for the welfare of the participant.
Unit=one modification or adaptation at accepted job bid.

Financial Management - To provide an analysis of the client's current financial & insurance status and assist client in resolving those problems identified. Financial management can involve one or more of the following:

- Organization and verification of the client's financial information and medical claims through direct contact with involved providers and creditors.
- Processing of medical statements against insurance benefits on an ongoing basis.
- Provision of a complete budget and financial strategy to the client including negotiation of a debt repayment program that would allow him/her to resume management of his/her own financial affairs.
- Implementation of the above stated financial strategy on behalf of the client. Power of Attorney or Representative Payee may be required for this service.
  Unit = 15 minutes of service provided.

Fiscal Intermediary (FI) – The Fiscal Intermediary assists the participant that chooses the Self-Determination Program, or their representative, to manage and distribute funds for purchasing goods and services authorized in the individual plan of services. Fiscal Intermediary services include, but are not limited to, the facilitation of the employment of service workers by the individual, including Federal, state and local tax withholding/payments, unemployment compensation fees, wage settlements; fiscal accounting; tracking and monitoring participant-directed budget expenditures and identifying potential over and under expenditures; assuring compliance with documentation requirements related to management of public funds; and, performing other supportive functions that enable the participant to self-direct needed services and supports.
Unit = Specified in FI contract.

Goods and Services – The purchase of services, equipment, or supplies not otherwise available through the MI Choice Waiver or the Medicaid State Plan that address an identified need in the individual client's plan of care, including improving and maintaining the participant's opportunities for full membership in the community.
Unit=15 minutes or one item.

Home Delivered Meals (HDM) - The provision of one to two nutritionally sound meals per day to a participant who is unable to care for their own nutritional needs. The unit of service is one meal delivered to the participant's home or to the participant's selected congregate meal site that provides a minimum of one-third of the current recommended dietary allowance (RDA) for the age group as established by the Food and Nutritional Board of the National Research Council of the National Academy of Sciences.
Unit = One meal, two cans (liquid meal), one can (supplement).

Homemaker - Services consisting of general household tasks (meal preparation and routine household cleaning and maintenance) provided by a qualified homemaker, when the individual regularly responsible for these activities is temporarily absent or unable to manage the home and upkeep for him or herself or others in the home. This service also includes observing and reporting any change in the participant's condition and the home environment to the supports coordinator.
Unit = 15 minutes.

Medication Management - Direct assistance to Care Management clients in managing the use of both prescription and over the counter (OTC) medications. Allowable program components include:

- Face-to-face review of client's prescription and OTC medication regimen and use of herbs and dietary supplements.
- Regular set-up of medication regimen.
- Supervision of compliance with medication regimen.
- Cueing via home visit or telephone call.
- Communicating with referral sources (physicians, family members, primary care givers, etc.) regarding compliance with medication regimen.
  Unit = 15 minutes.

Nursing Services – Services are covered on an intermittent basis for a participant who requires management of a chronic illness or physical disorder in the participant's home. Services can be provided by a registered nurse (RN) or a licensed practical nurse (LPN) under the direct supervision of an RN. MI Choice Waiver Nursing Services are for participants who require more periodic or intermittent nursing than available through the Medicaid State Plan or other payer resources for the purpose of preventive interventions to reduce the occurrence of adverse outcomes for the participant such as hospitalizations and nursing facility admissions.
Unit=15 minutes.

Personal Care – A range of assistance to enable program participants to accomplish tasks that they would normally do for themselves. This may take the form of hands-on assistance (actually performing a task for the person) or cueing to prompt the participant to perform a task. Health-related services that are provided may include skilled or nursing care to the extent permitted by State law. Personal Care includes assistance with eating, bathing, dressing, personal hygiene, and activities of daily living. This service may also include assistance with the preparation of meals but does not include the cost of the meals. When specified in the plan of care, this service may also include such housekeeping chores as bed making, dusting and vacuuming, which are incidental to the service furnished, or which are essential to the health and welfare of the individual, rather than the individual's family.
Unit = 15 minutes.

Personal Emergency Response System (PERS) - An electronic device which enables participants to secure help in an emergency. The participant may also wear a portable "help" button to allow for mobility. The system is connected to the participant's phone and programmed to signal a response center once a "help" button is activated. The response center is staffed by trained professionals. Installation, upkeep, and maintenance of devices/systems are also provided, including replacement of pendants, and are part of the monthly charge.
Unit = Per month.

Private Duty Nursing/Respiratory Care – Private Duty Nursing/Respiratory Care (PDN/RC) services are skilled nursing or respiratory care interventions provided to a participant age 21 and older on an individual and continuous basis to meet health needs directly related to the participant's physical disorder. PDN/RC includes the provision of nursing assessment, treatment and observation provided by licensed nurses within the scope of the State's Nurse Practice Act, consistent with physician's orders and in accordance with the participant's PCSP. All Respiratory Therapists providing respiratory care to participants must meet licensure requirements and practice standards found in MCL 333.18701-333.18713 and maintain a current State of Michigan respiratory therapist/care license.
Unit = 15 minutes.

Respite Care (provided inside the home) - Services provided to individuals unable to care for themselves; furnished on a short-term basis because of the absence or need for relief for those individuals normally providing services and supports for the participant.
Unit = 15 minutes.

Respite Care (provided outside the home) – Services provided to individuals unable to care for themselves; furnished on a short-term basis because of the absence or need for relief for those individuals normally providing services and supports for the participant, in a licensed Adult Foster Care facility or Nursing Home and includes the cost of room and board.
Unit = One day.

Specialized Medical Equipment and Supplies – Specialized medical equipment and supplies include devices, controls, or appliances, specified in the plan of care, that enable participants to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live. This service also includes items necessary for life support, or to address physical conditions along with ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment and medical supplies not available under the Medicaid State plan that are necessary to address participant functional limitations. All items shall meet applicable standards of manufacture, design, and installation. Waiver funds are also used to cover the costs of maintenance and upkeep of equipment. The coverage includes training the participant or caregivers in the operation and/or maintenance of the equipment or the use of a supply when initially purchased.

Unit=Per item.

Training Services - Instruction provided to a participant or caregiver in either a one-to-one situation or a group basis to teach a variety of independent living skills, including the use of specialized or adaptive equipment, or medically-related procedures required to maintain the individual in a home or community based setting. The training needs must be identified in the comprehensive assessment or in a professional evaluation and included in the plan of care as a required service. Training in the following areas will be covered: activities of daily living; adjustment to home or community living; adjustment to mobility impairment; adjustment to serious impairment; management of personal care needs; the development of skills to deal with service providers and attendants; effective use of adaptive equipment. For participants self-directing services, training may also include the training of independent supports brokers, developing and managing individual budgets, staff hiring, training, and supervision, or other areas related to self-direction.
Unit = 15 minutes.

Who Is Served

Care Management services are designed to inform, assist and coordinate a variety of home care and other community-based services needed by the elderly and other adults with disabilities who meet the nursing facility level of care. Services begin with an assessment by care managers followed by a plan of care that takes into consideration natural supports and community resources to meet each participant's identified needs.

Care managers arrange for service provision on behalf of the client, and/or purchase in-home health and social services and supports established in the plan of care. Participants receive follow-up and monitoring by care managers to assure that the plan of care is implemented as written and according to participant's preferences. Reassessments are provided, as is social and emotional support for the participants and their caregiver(s). Care managers serve as advocates for their clients.

MI Choice Waiver – Funded through the Michigan Department of Health and Human Services (MDHHS), the purpose of the MI Choice Waiver program is to build and strengthen home and community-based service capacity so that long term care setting preferences for person participating in the program can be fully supported.

MI Choice Waiver recipients must be aged 65 and older, or aged 18 to 64 years and disabled, meet medical criteria for nursing home admission, meet financial eligibility requirements, and need at least one of the Waiver services on a continuing basis. Services are provided according to an agreed-upon care plan.

Medical eligibility criteria are the same as defined by the state Medicaid agency for authorizing payment to nursing homes. Accordingly, persons served must meet nursing home placement criteria as a condition to receive in-home Waiver services.

To be financially eligible, a person must have a monthly income at or less than 300% of Supplemental Security Income (SSI) and meet the traditional Medicaid limits for assets. Spousal impoverishment asset rules apply to married couples when one of the individuals needs the program.

Care managers define need based upon assessment results and implement services appropriate to defined needs. MI Choice Waiver recipients receive traditional Medicaid coverage and are eligible for additional services.

ACLS Bureau Care Management (CM) – Care Management services are funded through the State's Older Michiganians Act. Clients must be 60 years of age or older to qualify for this program. Finances are not a component of eligibility, but clients must meet medical criteria for nursing home admission. Services are provided to individuals with functional limitations.

CM services are defined as the provision of a comprehensive assessment, care plan development, periodic reassessment, and ongoing coordination and management of in-home and other supportive services to individuals aged 60 and over who are in need of a nursing facility level of care due to the presence of functional limitations. Services are brokered or directly purchased, according to an agreed-upon care plan, to assist the client in maintaining independence. CM functions include eligibility determination, assessment, care plan development/supports coordination, reassessment and on-going monitoring. Activities shall be conducted in accordance with established performance criteria.

ACLS Bureau Case Coordination and Support (CCS) – CCS services are funded through the Federal Older Americans Act and the State's Older Michiganians Act. Finances are not a component of eligibility, and services are provided to individuals with minimal limitations.

CCS services are defined as the provision of a comprehensive assessment of persons aged 60 and over with a complementing role of brokering existing community services and enhancing informal support systems when feasible. CCS includes the assessment, reassessment of individual needs, development and monitoring of a service plan, identification of and communication with appropriate community agencies to arrange for services, evaluation of the effectiveness and benefit of services provided, and assignment of a single individual as the caseworker for each client.

ACLS Bureau Options Counseling (OC) - OC services are funded through the State's Older Michiganians Act. OC is an interactive process where participants (including family members and caregivers) receive guidance in their deliberations to make informed choices about long-term supports and services. The process is directed by the participant and may include others that the participant chooses or those who are legally authorized to represent the participant. Finances are not a component of eligibility and services are provided to individuals with minimal limitations.

Funding Sources/Reimbursement Structure

Through the ACLS Bureau and the MDHHS, the CM program utilizes funds from the Federal Centers for Medicare and Medicaid Services (CMS), administrators of Medicaid; Federal Title III of the Older Americans Act; state funds of the Older Michiganians Act; and other state and local resources to purchase services otherwise unavailable to clients through existing payments and/or service structures.

The AAA uses a unit cost reimbursement structure to purchase services from community providers. The Demographic and Rates form, submitted during the application process, establishes a fixed unit cost reimbursement rate or case-by case rate (if applicable) for each unit of service delivered. Reimbursement received by a subcontractor from AAA is based on the number of units of service provided.

Provider Eligibility Standards

Eligible Organizations - Public, private non-profit or profit-making service organizations and political subdivisions of the state who offer services which meet the AAA's minimum standards, certifications, and/or licensure requirements, and who service the Michigan counties of Berrien, Cass and/or Van Buren are eligible to apply to deliver services.

All residential setting providers (i.e. adult foster care, assisted living facility, home for the aged) where individuals live and non-residential setting providers (adult day care facility) must be in compliance with the MDHHS Home and Community Based Services (HCBS) final rule, which establishes requirements for these settings in which individuals receive services.

Service Compliance - Compliance with Federal regulations is required by service providers. Assurances certifying compliance with the following by service providers are part of the application process and Provider Enrollment Agreement.

- **Medicaid Provider Manual MI Choice Chapter**- Service providers agree to adhere to the definitions and minimum service standards to be eligible to receive reimbursement of allowable expenses.
- **Civil Rights Compliance** - Service providers must not discriminate against any employee or applicant for employment, or against any MI Choice participant pursuant to the Federal Civil Rights Act of 1964, the Elliot-Larsen Civil Rights Act (P.A. 453 of 1976) and Section 504 of the Federal Rehabilitation Acts of 1973. Service providers must clearly post signs at agency offices and locations where services are provided, in English and other languages as appropriate, indicating non-discrimination in hiring, employment practices, and provision of services.
- **Equal Employment** – Service providers must comply with equal employment opportunity principles in keeping with Executive Order 1979-4 and Civil Rights Compliance.
- **Standard Precautions** – Service providers must evaluate the occupational exposure of employees to blood or other potentially infectious materials that may result from the employee's performance of duties. Providers must establish appropriate standard precautions based upon the potential exposure to blood or infectious materials. Providers with employees who may experience occupational exposure must develop an exposure control plan that complies with the Federal regulations implementing the Occupational Safety and Health Act.
- **Drug Free Workplace** – Service providers must prohibit the unlawful manufacture, distribution, dispensing, possession, or use of controlled substances in the workplace.
- **Americans with Disabilities Act as Amended (ADAAA)** – Service providers must operate in compliance with the Americans with Disabilities Act (29 CFR 1630 – 2008,2009,2010)
- **Debarment and Suspension –** Service providers must comply with Federal Regulation, 2 CFR Parts 180 which assures that it, its employees, and its subcontractors are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal department or contractor.

Person-Centered Planning Process – Service providers shall embrace the philosophy of person- centered thinking that recognizes that all participants are unique individuals with needs, wants, goals and dreams. Most people want the same things from life; an interesting and meaningful daily life, close relationships with others, opportunities to socialize and enjoy recreation, opportunities to develop talents and abilities, to be a part of and contribute to the community, and to feel valued and important. The person-centered approach is designed to encourage people working with individuals in long-term care situations to view the individual's needs through their eyes and to honor their preferences, choices, and abilities.

Contributions and Solicitation – Service providers are prohibited from charging fees for services or requiring monetary donations. No paid or volunteer staff may solicit contributions from program participants, offer for sale any type of merchandise or service, or seek to encourage the acceptance of any particular belief or philosophy by any program participant.

Care Coordination and Support and Care Management (non-Waiver) participants may be asked by the AAA to contribute to the cost of their services by cost sharing using a self-declared income sliding scale. Services will not be denied due to failure to pay agreed upon cost share/donation payments. Cost sharing payments/donations shall not be handled by the provider or their worker on behalf of the client but must rather be mailed to or picked up by the AAA Care Manager.

Insurance - Service providers shall have sufficient insurance to indemnify loss of Federal, State and local resources, due to casualty or fraud, and to cover the fair market value of the asset at the time of loss. Insurances required for each program are:

1. Workers compensation
2. Unemployment
3. Property and theft coverage
4. Fidelity bonding (for persons handling cash)
5. Facility insurance (for facilities purchased with Federal and/or State funds)
6. No-fault vehicle insurance (for agency owned vehicles)
7. General liability

Additional insurances, as appropriate, are recommended for additional agency protection:

8. Insurance to protect from claims against drivers and/or passengers
9. Professional liability
10. Insurance for Board members and officers
11. Special multi-peril

As part of the application process, service provider must provide evidence of liability insurance.

Failure to supply evidence of insurance and licensure may result in holding payment until evidence is supplied or termination of contract. In addition, Residential Services providers must provide Residential Care Agreements, Assessment Plans, and Appraisals annually, failure to do so may result in holding of payment until evidence is supplied.

Confidentiality - Service providers shall have procedures in place to protect the confidentiality of information about participants or persons seeking services. The procedures must ensure that no information about a participant or person seeking services, or obtained from a participant, is disclosed in a form that identifies the person without the informed consent of that person or of his or her legal representative. However, disclosure may be allowed by court order, or for program monitoring by authorized Federal, State, or local agencies (which are also bound to protect the confidentiality of the client information) so long as access is in conformity with the Privacy Act of 1974, the Health Insurance Portability and Accountability Act of 1996, the Health Information Technology for Economic and Clinical Health Act of 2009, and the Omnibus Act of 2013. Service partners shall maintain all client information in controlled access files. This requirement applies to all protected information whether written, electronic, or oral.

Service Back-up Plan/Service Need Level – The Service Back-up Plan can be found on each participant in Vendor View. On the Service Back-up Plan a service need level is indicated. Please see Grid of Service Need Levels at the end of this document.

Service need level is determined by the Supports Coordinator (Care Manager) for each participant based on the participant's needs and preferences. Service providers are expected to be aware of the service need level of each participant and follow the back-up plan when services are not provided as authorized.

Priority 1A and At-Risk clients **MUST** receive service as authorized. There can be **NO** missed visits for priority 1A and At-Risk clients. Service 1B clients should follow the back-up plan as defined in the Service Back-up Plan (this may include a preference for a backup worker to be located, or for an informal support to provide care). If for any reason a priority 1A, 1B, or 1C client goes without service the client, or their designee (family, guardian, designated contact person) as defined on the Service Back-up Plan and the Supports Coordinator must be notified immediately.
Regardless of service need level the service provider must notify the participant and or their designee and submit a non-Service message in Vendor View to the Supports Coordinator when services will not be provided as authorized for any reason (worker call off, weather emergency, etc.)

When service providers are no longer able or willing to staff a participant, they must provide the Supports Coordinator with 10 business day notice for priority 1A, 1B, 1C before terminating services. For all other priority ratings 5 business day notice is required.

Emergency Coordination - Service providers are required to have a contingency emergency plan for situations that pose a serious threat to participant health and welfare (i.e., inclement weather, unavailable caregivers, natural disasters, etc.). The contingency plan must utilize the participant's service need level established by the AAA so that participants with the most critical needs are served first when emergencies limit the amount of care available in the area. Should lower priority clients not have their service needs met due to redirection of staff, procedures should require placing a call to the participant or their designee, and the Supports Coordinator plus sending of the Non-Service message in Vendor View.

A copy of the Provider's Emergency Coordination Plan detailing how the provider will ensure the continuation of services for Priority 1 participants should be included with the New Provider Enrollment Agreement. Providers must arrange to have available their staff 24 hours one or more qualified professionals for the purpose of supervision, problem solving and back-up.

Adult Foster Care homes are required to submit a copy of their Emergency Plan, including a plan for staffing under emergency situations as well as an evacuation plan.

Medication Management - Service providers are required to have a policy and procedure to effectively and appropriately manage medications for participants.

Abuse, Neglect, Exploitation and Other Incidents - Service providers are required to have a policy and procedure that outlines appropriate actions to take upon the determination of incidents of abuse, neglect, exploitation, and other critical incidents threatening the health or emotional well-being of the client. The policy should also establish regular review of these policies and procedures with staff.

Staffing Requirements

Employees

- Service providers shall employ competent personnel sufficient to provide services pursuant to the contractual Agreement.
- Service providers must thoroughly check references of paid staff or volunteers who will be working directly with participants **before hiring**. In addition, the provider must conduct a criminal background check (CBC) through the Michigan State Police (ICHAT), the Michigan Public Sex Offender Registry, and the National Sex Offender Registry for each paid and/or volunteer staff person who will work directly with a participant or has access to participant information **before hiring** and before authorizing to furnish services and **then every third anniversary** from the date of their previous CBC. Additional information on CBC requirements, including exclusion guidelines, can be found on the AAA website: https://areaagencyonaging.org/providers/.
- Service providers shall check both the Federal (OIG) and State (SAM) sanction database on a monthly basis to certify services are not provided by a sanctioned employee.
- Providers of Community Transportation (excluding public transportation) shall have in place a process to disclose the driving history, including any traffic violations, of each such individual driver employed by the provider.
- Direct Service workers must complete the Michigan Adult TB Risk Assessment upon hire, to determine the need for a TB test, and annually thereafter.
- Service providers shall demonstrate an organizational structure with established lines of authority.

- Service providers shall identify a contact person with whom the AAA can discuss work orders and service delivery schedules.

Staff Qualifications and Conduct – Service providers of in-home services will assure that the following additional conditions and qualifications are met by their employees and volunteers:

- Service providers must have procedures in place for obtaining participant signatures on time sheets (or similar document) of direct care workers to verify that the direct service worker provided the work ordered by the AAA. Electronic Visit Verification systems may take the place of this requirement as long as the verification is available.
- Direct service workers are prohibited from smoking in participant's homes.
- Direct service workers must be able to adequately and appropriately communicate, both orally and in writing, with participants they serve. Direct service workers must be able to properly follow instructions in carrying out direct service responsibilities (i.e., read grocery lists, identify items on grocery lists, and properly use cleaning and cooking products).
- Direct service workers must not use their cell phones for personal use while in a participant's home. Exceptions may be made in cases of emergency.
- The Direct service workers should engage with the participants while furnishing the services specified on the person-centered service plan.
- Direct service workers must not threaten or coerce participants in any way. Failure to meet this requirement shall be grounds for immediate discharge.
- Direct service workers are prohibited from taking pets, children, friends, or family into the client's home.
- Direct service workers are prohibited from discussing personal business with the client, or from discussing another client's business with the client.
- Direct service workers shall be instructed that their timesheets are not to be signed by clients prior to completing work assignments.

Staff Identification – Service provider representatives, whether paid or volunteer, who enter a participant's home must display proper identification. Proper identification may consist of either an agency picture card or a Michigan's driver's license coupled with another form of agency identification.

Supervision – Staff supervision will be conducted by the service provider by a qualified professional. A registered nurse licensed to practice nursing in the State of Michigan shall furnish supervision of workers providing Community Living Supports or Personal Care. The direct care worker's supervisor shall be available to the worker at all times the worker is furnishing services. Home-based service providers must conduct in-home supervision of their staff at least twice each fiscal year.

Training – Service providers shall participate in relevant in-service training workshops as appropriate and feasible. New staff members must receive an orientation training that includes, at a minimum, introduction to the AAA Care Management program, the aging network, basic health and welfare, maintenance of records and files as appropriate, the aging process, person-centered thinking, working with individuals with disabilities, identification and reporting of elder abuse, neglect, and/or exploitation, basic first aid, emergency procedures, and ethics (including acceptable work ethics, honoring participant dignity, respect of participant and their property, prevention of theft of participant belongings). Details of training dates and topics will be maintained by the service provider for each staff member in individual employee personnel files.

Employees of in-home service providers must receive in-service training at least twice each fiscal year that is specifically designed to increase their knowledge and understanding of the program and participants, and to improve their skills at tasks performed in the provision of service. An individualized in-service training plan for

each employee will be developed when performance evaluations indicate a need. Providers shall provide training topics specific to the minimum service standard for service categories being provided through the Agreement.

All service providers are required to complete Fraud, Waste, and Abuse training during the first 90 days of hire and annually thereafter. Evidence of completion may be in the form of a training log. The training course is located on the AAA website: https://areaagencyonaging.org/providers/. This training can also be used to fulfill one of the two required trainings for in-home service providers each fiscal year.

The appropriate form to complete and submit to report suspicion of fraud, waste, or abuse is also located on the AAA website.

Volunteers - Service providers utilizing volunteers shall have a written procedure governing the recruiting, training, and supervision of volunteers. Volunteers shall receive a written position description, orientation, training, and a yearly performance evaluation as appropriate.

Contractual Agreement, Enrollment, and Rates

A formal Provider Enrollment Agreement will be established between the AAA and each service provider. The Provider Enrollment Agreement is open-ended, remaining in effect until terminated or replaced by a subsequent executed Provider Enrollment Agreement.

Agencies requesting to provide services under the AAA Care Management program will receive program requirements from the AAA and are required to complete and submit a full application which includes the Provider Enrollment Agreement; the DSP Operational Guidelines and Procedures and Medicaid Provider Manual-MI Choice Chapter provided during the application process are considered part of the Provider Enrollment Agreement. All subsequent amendments to the DSP Operational Guidelines and Procedures, as well as Medicaid Provider Manual-MI Choice Chapter as distributed by AAA, MDHHS, or the ACLS Bureau, become part of the Provider Enrollment Agreement.

The AAA will review applicant requests to determine that providers are qualified to provide requested services. The AAA will enroll the provider as a Medicare/Medicaid provider using the Provider Enrollment Agreement, the Business Associate Agreement, and the Medicaid Provider Enrollment Agreement.

An orientation for providers will be provided by the AAA to describe characteristics of the target population, level of care criteria, medical eligibility, and program description and requirements. Additional information or technical assistance will be available to providers as necessary.

Selection of Providers

Providers will be selected as needed on an individual basis according to the following criteria:

- **Participant Preference** – If the participant desires a specific provider, preference will be given.
- **Cost -** The cost of services is a factor in selecting a service provider.
- **Accessibility -** Practical considerations involved in selecting a provider include the provider's geographic area of service and ease of service delivery to the participant.
- **Ability to Provide Quality Service** - The provider's past performance in furnishing quality services is considered. Quality includes performance, participant outcome, and accountability.
- **Comprehensive Care -** The AAA shall make a reasonable effort to minimize the number of different agencies involved in providing services to participants in order to provide continuity and limit family stress. The ability of the provider to provide the different types of services needed by the participant is considered.

Native American participants are permitted to obtain covered services from out-of-network Indian Health Care Providers (IHCPs) from whom the participant is otherwise eligible to receive such services.

Service Orders and Communications

Depending on the type of service being ordered, AAA staff may issue Vendor View Notifications or make direct contact to multiple service providers simultaneously for services to be provided for a participant. General information about the geographic location, type of service needed, frequency of service, and the participant's preferred days/times of service will be communicated to potential providers. Providers responding to the request letting AAA know the availability of services they can provide, including specifics such as the worker's name, will receive first consideration. **Providers will not be paid for services not authorized nor should they start services until a service order authorizing care is received.**

Communication of service orders will occur via the Vendor View system. All providers working with AAA must sign up to receive communications via Vendor View. All Vendor View Notifications must be archived within one business day. The archiving of Notifications of service orders in Vendor View informs the AAA that the provider has accepted the service authorization. Additional information about Vendor View can be found on the AAA website: https://areaagencyonaging.org/providers/.

Once an order is accepted and confirmed, all further communication regarding the participant is done directly between the provider and the AAA Care Manager assigned to that participant. Services may need to be cancelled on short notice. Services cannot be paid for days/times the participant is not in the home, regardless of spouse or family member requests. Meals cannot be reimbursed if not able to be delivered to the participant.

Providers are required to notify the AAA of any changes in the client's condition, as they become aware of them. These changes are outlined in the "Direct Provider of Service Mandatory Notification Requirements."

Reporting and Payment System

Providers receive payment for services on a monthly basis by submitting monthly client bills to the AAA detailing the date of service, the type of service, the unit cost, and the total number of units provided for services provided. Submissions must cover a one-month period; the first day of the month through the last day of the month. To receive prompt payment, submissions are due to the AAA by the 10th of each month following the month in which the service was provided and must be complete and accurate. The submissions are checked, matched, and verified according to the care plan and the services ordered, with payment issued by the last business day of the month. If the information submitted is incomplete or incorrect, payment will be delayed until the necessary corrections are submitted and approved for payment.

It is expected that all invoices will be submitted within **90 days** of service provision. If a provider is unable to submit an invoice within 90 **days,** please contact the AAA Data Department. Depending on the circumstances, AAA may refuse to accept the late invoice. Invoices that have been previously submitted and returned for revision are expected to be corrected and resubmitted within 30 days. **In order to accommodate the AAA's fiscal year end closing date of September 30th, all invoices for a given fiscal year must be submitted by October 30th following the conclusion of the fiscal year.**

Providers are advised to keep copies of all reports and bills submitted, whether mailed, faxed, or delivered. Report forms are furnished by AAA that may be duplicated by the provider for use. Report forms are also available in digital format. AAA report forms should be used; however, providers may use their agency's report form with prior approval from the AAA. Providers are encouraged to submit monthly bills electronically through Vendor View.

Direct Service Purchase Monthly Service Reporting Form - Complete one form per client served and use more than one form if more than six services are provided per client for the reporting month.

- Part I - General and Client Information - Indicate the month the report covers. Insert the name of the agency completing the form and the agency phone number. Document the client's last name and first name, last four digits of their social security number (SSN), date of birth (DOB), and program assignment as indicated on the AAA Service Order/Confirmation Form.
- Part II – Service Delivery – List each service provided for the month and below the appropriate date of the month list the number of units provided for each service. **Units billed must be confirmed by worker timesheets.**
- Part III - Billing Information and Notes/Comments - The box supplies space to list the total number of units provided for the month for each service, unit cost, and calculation of the amount of funding being requested. If completing the form electronically, service units and total will be populated automatically, only the authorized cost for each service will need to be input manually. The Notes/Comments section on the form provides space to comment on any of the information submitted.

Monthly Summary Report - The Monthly Summary Report is submitted as a batch summary of all individual DSP Monthly Service Reporting forms. If completing the form electronically, the Total will calculate automatically once the Total Units and Unit Cost fields are populated for each service provided. Use more than one form if more than 8 unique services were provided within the reporting month. Please make sure all applicable fields are completed and verified; the form must be signed and dated certifying that the information submitted is correct. The AAA will provide technical assistance to agencies as requested. Please call the AAA should questions arise regarding the billing process.

Complaint Resolution and Monitoring System

The quality of services provided is monitored on a continual basis through customer and community feedback, AAA staff input, and on-site monitoring of providers to assure that services are being delivered as planned to the satisfaction of the participant.

Service providers of in-home services must notify each participant, in writing, at the time service is initiated of his or her right to comment about the service provision or to appeal the termination of services. Such notice must advise the participant that he/she may file complaints of discrimination with AAA, U.S. Department of Health and Human Services Office of Civil Rights, or the Michigan Department of Civil Rights.

Service providers must have written complaint resolution procedures. Complaints about the quality of service are reviewed, and the AAA conducts follow-up activities with the provider. Clients and/or their families are surveyed regularly to solicit input about the quality of the provider's performance and satisfaction with the services provided. In response, care plan revisions may be made accordingly as appropriate.

Monitoring of service providers by the AAA are carried out by the AAA to insure:

- Compliance to Medicaid Provider Manual-MI Choice Chapter and conditions of participation.
- Delivery of services according to authorized care management client care plans.
- Maintenance of adequate staff recruitment, training plans, and staff supervision.
- Maintenance of client case record documentation to support claims.

On-Site Monitoring - On site provider monitoring visits are conducted by the AAA during the course of the year and may be requested and scheduled with the provider at any time. A sample of the DSP provider pool will be selected annually for on-site monitoring visits with the following criteria used:

- A percentage of the Direct Service Purchase service providers are reviewed following MI Choice Waiver guidelines;
- During the visit, a sample of at least 10 client case records or 10% of the provider records are reviewed;
- Verification of appropriate documentation in files;

- Verification of service claims and reimbursements for three months for each client record.
- Verification of date of service, time of service delivery, staff providing the service, and supervision of staff providing the service.

Home Visits - From the sample of participant case records reviewed, AAA staff may select program participants to conduct a home visit. These visits are to evaluate client satisfaction with care management activities and services, and to verify that providers deliver services as planned.

Follow-up - The AAA will provide written findings of the review and corrective action requirements (as necessary) to the provider following completion of the initial review. Providers will respond to required corrective action as instructed by the AAA written findings. Completed reports are sent to the Michigan Department of Health and Human Services. Providers found to be in non-compliance and who do not notify or respond to the AAA notice of corrective action as instructed will be subject to sanctions as determined by the AAA. This applies to both items of non-compliance determined as a result of the monitoring visit, as well as to the result of investigation of a participant's complaint.

Records

Providers are required to maintain participant records, including assessments, care plans, service or contact logs, reassessment, quality assurance records, and all case and financial records for a period of a minimum of ten (10) years from the close of the previous fiscal year to support an audit trail. The AAA's fiscal year is October 1 through September 30 of the following year.

Providers will maintain a case record either on paper or in Vendor View or a combination of the two, for each program participant that includes:

- Service work orders/authorizations;
- Assessments or the parts of the assessment provided by the AAA. Service providers will avoid duplicating assessment or reassessments of individual participants to the maximum extent possible by accepting the assessment conducted by the AAA. Services are to be provided without having to conduct a separate assessment or reassessment;
- Progress notes and supervisory notes;
- In-home service providers will include a record of release of any personal information about the client and/or a copy of a signed release of information form;
- Services provided to each participant (a description of tasks completed by date of service, worker notes describing the tasks completed for each time period, and/or in-home service logs). The in-home log is retained in the home and is a daily account of tasks accomplished and is written by the worker who provides the service. It should include at a minimum the participant's name, number of units, date and time the units were provided (in/out), service category, brief description of major tasks accomplished, and a signature of the worker for each entry. Worker time sheets may not be used as service logs. Service logs more than 30 days old may be transferred from the home to the case record;
- Adult Foster Care and Assisted Living Home service providers are required to have in each client file and provide at least annually to the AAA, an updated copy of each participant's Resident Care Agreement, Assessment Plan, and Health Care Appraisal. These forms can be the standard versions as developed by LARA, or else must contain equivalent information. All forms must be filled out completely and signed to be considered valid.

Service Partner Responsibilities

Service providers receiving funds through the AAA will cooperate with AAA publicity and promotional efforts as directed by the AAA. However, providers shall not use the AAA name or logo in its marketing efforts in any form

or fashion which states, suggests or otherwise infers special status above other enrolled providers or access to the MI Choice Waiver Program or AAA's Care Management system.