# WAIVER CARE MANAGER GUIDANCE:

## COORDINATING MEDICAID STATE PLAN HOME HEALTH SERVICES (HH) & WAIVER ATTENDANT CARE SERVICES (ATTC)

The purpose of this document is to provide guidance to all care managers regarding the necessary coordination of Medicaid State plan home health services and waiver attendant care services. This document is organized into the following sections:

- Frequently Asked Questio.ns. This section provides basic information to care managers about home health services, coordination with waiver attendant care services, the prior authorization process, and the impacts on waiver service planning and review/approval.
- Conversation with Individuals/Families. This section provides information about the care manager's responsibility to discuss home health services with individuals/families and provides sample questions to help the care manager determine whether an individual/family has requested home health services and their status in that process.
- Documentation and Next Steps. This section provides information about what home health documentation a care manager must include when submitting a waiver service plan that includes attendant care services. Documentation requirements vary depending upon the status of the individual's home health service request.

## Frequently Asked Questions

| Question | Answer |
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| What are Home Health Services? | Home health services include skilled nursing, home health aide services and skilled therapies (physical therapy, occupational therapy and speech-language pathology) for those who meet medical necessity and eligibility indicators. For additional details related to activities supported through each service, see Home Health Services IHCP Provider Reference Module. |
| Do individuals requesting waiver Attendant Care services need to request State Plan Home Health Services first? | Yes. Waiver services complement and/or supplement the services that are available through the Medicaid State plan and other federal, state and local public programs as well as the support that families and communities provide to individuals. Waiver services are the payor of last resort. Therefore, prior to requesting Attendant Care Services under a Medicaid waiver, the individual/family must seek prior authorization for home health aide services under the Medicaid State Plan or demonstrate why Home Health services are not appropriate for the individual. |
| Why do Individuals requesting Waiver ATTC need to request home health services from State Plan? | The HCBS Waiver Program provides services that complement Medicaid State Plan services, other federal, state, and local public programs, and support from families and communities to avoid institutionalization. To best support individuals and families, care managers should assist in identifying an array of integrated supports, including home health services from their Medicaid State Plan. |
| Who Are Home Health Services Appropriate for? | As outlined in the Home Health Services IHCP Provider Reference Module, Home health services are appropriate for individuals with at least one indicator from each of the following two categories:<br><br>Category I: Member<br>• The member is at risk of respiratory failure, severe deterioration or hospitalization without constant monitoring.<br>• The member requires total care – monitoring 24 hours per day. |

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| | • The member desires to stay in the home, rather than in a long-term care (LTC) facility.<br>• The medical condition of the member has deteriorated, creating the need for more intense short-term care (practitioner's statement required).<br><br>Category II: Caregiver<br>• The member does not have a primary caregiver or access to other care.<br>• The caregiver is employed and absent from the home or is unable to provide the necessary care.<br>• The caregiver has additional child-care responsibilities, disallowing the time needed to care for the member (three or more children under 6 years of age, or four or more children under the age of 10).<br>• The caregiver has additional children with special needs to care for (one or more children with special healthcare needs requiring extensive medical and physical care).<br>• A caregiver is experiencing a major illness or injury, with expectation of recovery.<br>• There is a temporary but significant change in the availability of a caregiver – for example, military service.<br>• There is a significant permanent change in a caregiver's status – for example, death or divorce with loss of one caregiver.<br><br>It is not the responsibility of the care manager/service coordinator to determine whether an individual meets these criteria. That determination is made through the Prior Authorization process for Home Health Services. |
| How do individuals request State Plan Home Health services? | An authorized representative of the home health agency or the members physician can work with the individual/family to submit PA requests for home health agency services, along with required supporting documentation.<br><br>The medical necessity for home health services must be certified by the member's qualified treating practitioner (physician, nurse practitioner, clinical nurse specialist or physician assistant). A face-to face encounter is required for the initial certification of medical necessity of home health services.<br><br>Generally, all home health services require prior authorization (PA) (exceptions described in Home Health Services IHCP Provider Reference Module). |
| What is a Prior Authorization (PA)? | Prior authorization refers to a requirement by Indiana's Health Coverage Programs (IHCP) for individuals to obtain approval for service(s) prior to the care being provided.<br><br>Additional information about Prior Authorization processes and requirements can be found in the Prior Authorization IHCP Provider Reference Module and the Fee-for-Service Prior Authorization webpage. |
| What kinds of "supporting documentation" is required to be submitted with a PA request? | Home Health PA Supporting Documentation typically includes:<br>• A copy of the written plan of treatment for HH services<br>• Documentation of a face-to-face encounter to certify medical necessity<br>• Time, intensity, and cost estimates for HH services<br>• Information about other available resources (e.g. Educational Supports, Therapies, Familial Supports, and Community Resources).<br><br>For full details, please refer to the Home Health Services IHCP Provider Reference Module. |

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| How long can it take to get a doctor's referral for Home Health services? | The timeframe to get a doctor's referral will vary by doctor's office, and may be longer if a face-to-face appointment has not yet occurred within the last twelve months. |
| How long can it take to get an acceptance or rejection from a Home Health Agency? | The timeframe to get an acceptance or rejection from a Home Health Agency will vary by agency. We recommend following up with the Home Health Agency if the individual has not received a response within 5 business days. |
| How long will it take for Medicaid to review a PA request for Home Health services? | When all required information is submitted, PA requests are reviewed with determination within five (5) business days. If more information is needed the determination will take longer. |
| How long will it take for BDS to review a service plan that includes Attendant Care? | When all required information is provided, the BDS Service Plan Reviewer reviews service plans and makes a determination within 5-7 business days of receiving all required information.<br><br>It is important to note that this process will take longer if the individual/family has not completed the process for requesting Home Health services, and/or the CM has not properly documented the status of their request in CaMSS. |
| Where can I look for more information about Home Health services? | Home Health Services IHCP Provider Reference Module |
| What happens if an individual/family refuses to request a Home Health referral? | If an individual refuses to request a HH referral they are not eligible to request ATTC hours for any activities that could be supported under HH. |
| How does a Care Manager evaluate the appropriateness of ATTC hours? | The care manager should consider the totality of the individual's need, other services requested on the plan, services that are available through the Medicaid State plan such as home health, and other federal, state and local public programs as well as the supports that families and communities provide to individuals. The hours requested should meet the individuals assessed need and align with the intent and allowable activities of the service. |
| What does it mean if a service plan review status is "RFI Expired"? | When an RFI is sent to the CM, the CM has 21 business days to respond to the RFI and resubmit the service plan. A status of "RFI Expired" means the plan was not resubmitted before the deadline and the plan has been denied. The CM is required to re-enter plan and the review/approval process would re-start.<br><br>If the review is for an initial service plan, the start of the service plan will be delayed until all outstanding issues are resolved. If the review is for an annual service plan, the individual continues receiving services under their active plan (which auto-extends for 1 month). |

## Conversation Strategies

Care managers have a responsibility to have a conversation with the individual/family regarding the availability of HH services, and the process for applying for HH services, prior to requesting ATTC on a waiver service plan. The questions and answers grid above may be useful in guiding that conversation.

While a request for HH services is required prior to approving ATTC on a waiver service plan, individuals and families may be at a variety of different steps in that process. To determine where in the process an individual is, you may want to ask some or all of the following questions:

- Are you currently receiving Home Health services?
- Have you received a Home Health PA Determination Letter within the previous twelve months?
- Have you requested a Home Health referral from your doctor? If not, why not? (e.g., because they don't believe they meet the criteria? Or because the individual/family refuses to request referral?)
- Has your doctor completed/approved a Home Health referral?
- Has a Home Health Agency accepted the referral, or have you had difficulty finding a Home Health Agency?

## Documentation and Next Steps

Once you have identified the status of an individual/family home health request, review the scenarios below to identify which is most applicable to the individual's current situation. Then review and provide the required documentation for approval of ATTC. Documentation requirements and next steps vary depending upon the status of the individual's home health service request.

It is very important that the care manager provide all required information when submitting a service plan for review and approval. If the Service Plan Reviewer has to send a Request for Information, the CM must respond to the RFI within 7 calendar days. If no response is received, the plan status will be changed to "RFI Expired" and the care manager will be required to re-enter service plan before the review/approval process can re-start.

### The individual has an active HH PA

If an individual has an active Home Health PA, they may request additional ATTC services to meet their unmet personal care needs. As the CM, you should review the approved HH hours and work with the individual/family to identify the individual's unmet personal care needs. If there is an unmet personal care need, an appropriate amount of ATTC hours can then be requested on the service plan.

#### Documentation Requirement:

The Care Manager must complete one or more of the following:

- Upload a copy of the active Home Health PA approval letter (issued within the previous twelve months) in "Related Documents" in CaMSS.
- Document the active Home Health PA number and brief description of activities and hours of coverage in a Case Note in CaMSS. Also, in the Plan Alteration Comment Box, add the following reference: *"Additional HH PA Information in CN dated XX/XX/XX"*

The documentation should also describe how all other criteria for ATTC are met.

### The individual has requested and been denied a HH PA within the previous 12 months

If an individual has been denied a Home Health PA by IHCP within the previous twelve months, they may request ATTC services to meet their unmet personal care needs. As the CM, you should work with the individual/family to identify the individual's unmet personal care needs. If there is an unmet personal care need, an appropriate amount of ATTC hours can be requested on the service plan.

### Documentation Requirement:

The Care Manager must upload a copy of the Home Health PA denial letter (issued within the previous twelve months) in "Related Documents" in CaMSS. The documentation should also describe how all other criteria for ATTC are met.

## The individual believes they do not meet the required HH criteria

While it is not the care manager's responsibility to determine whether the individual meets HH criteria, it is important that there is clear documentation as to why the care manager and the individual/family believes the criteria is not met.

To be eligible to receive Home Health services, an individual must meet at least one indicator from each of the following two categories:

Category I: Member

- The member is at risk of respiratory failure, severe deterioration or hospitalization without constant monitoring.
- The member requires total care – monitoring 24 hours per day.
- The member desires to stay in the home, rather than in a long-term care (LTC) facility.
- The medical condition of the member has deteriorated, creating the need for more intense short-term care (practitioner's statement required).

Category II: Caregiver

- The member does not have a primary caregiver or access to other care.
- The caregiver is employed and absent from the home or is unable to provide the necessary care.
- The caregiver has additional child-care responsibilities, disallowing the time needed to care for the member (three or more children under 6 years of age, or four or more children under age 10).
- The caregiver has additional children with special needs to care for (one or more children with special healthcare needs requiring extensive medical and physical care).
- A caregiver is experiencing a major illness or injury, with expectation of recovery.
- There is a temporary but significant change in the availability of a caregiver – e.g., military service.
- There is a significant permanent change in a caregiver's status – for example, death or divorce with loss of one caregiver.

If there is clear documentation that individual/family does not meet the required HH criteria, they may request ATTC services to meet their unmet personal care needs. As the CM, you should work with the individual/family to identify the individual's unmet personal care needs. If there is an unmet personal care need an appropriate amount of ATTC hours can be requested on the service plan.

### Documentation Requirement:

The Care Manager must enter a "Case Note" with a clear explanation as to why the criteria for HH is not met (if there has not been a previous denial for HH outline how the individual does not meet each criteria in Category 1 and Category 2 (above). Also, in the "Plan Alteration Comment Box", the Care Manager must add the following reference: *"Additional HH PA Information in CN dated XX/XX/XX."* The documentation should also describe how all other criteria for ATTC are met.

Note: To support families in obtaining all the services that they may be eligible for to meet their assessed needs, care managers should work with individuals and families to request HH services as it is required that all applicable State Plan services be exhausted prior to accessing waiver services.

### Example Documentation:

In the Plan Alteration Comment Box: Additional HH PA Information in CN dated 06/05/24.

In Case Note: Bill's family requested HH and was denied on 5/3/2023 (denial attached). During the planning meeting held on 6/1/2024 Bill's family explained that there has been no change in Bill's needs or the family circumstances since that

time. Therefore, Bill's family does not believe he will meet the criteria for HH at this time. ATTC is being requested to support Bill with personal care needs related to bathing which requires two people. The ATTC provider will work alongside Bill's mom to complete these tasks.

## The individual refuses to request a Home Health referral

If an individual refuses to request a HH referral they are not eligible to request ATTC hours for any activities that could be supported under HH. If the individual/family indicates they are unwilling to request a HH referral, ask for additional clarification as to the reason.

If a request for HH had been made and denied more than twelve months prior and the individual's circumstances have not changed see the scenario above (The individual believes they do not meet the required HH criteria).

### Documentation Requirement:

The Care Manager must enter into a "Case Note" clear documentation that the individual/family refuses to request a HH referral and include the reason provided. Also, in the "Plan Alteration Comment Box", the Care Manager must add the following reference: *"Additional HH PA Information in CN dated XX/XX/XX."*

Any ATTC that is included in the plan must exclude services that can be provided under HH (See the Home Health Services IHCP Provider Reference Module for a detailed explanation of activities that can be provided under Home Health services)

## The individual is making or has made a recent request for an HH Referral from their doctor

If an individual has not yet requested an HH referral from their doctor within the previous twelve months, this must be completed prior to drafting a plan with any ATTC hours. The individual should contact their doctor for a HH Referral. Once an HH Referral Request has been made, the CM should monitor and document the outcome of that request in CaMSS.

*If the doctor has completed a HH Referral Request within the previous twelve months:* The service plan may include ATTC services to meet the individual's unmet personal care needs. As the CM, you should work with the individual/family to identify the individual's unmet personal care needs and request an appropriate amount of ATTC hours on the service plan.

### Documentation Requirement:

The Care Manager must enter the following information into a Case Note:

- Name of Physician/PA
- Name of Home Health Agency
- Date of Approval
- Number of Hours Approved

Also, in the "Plan Alteration Comment Box", the Care Manager must add the following reference: *"Additional HH PA Information in CN dated XX/XX/XX."*

The documentation should also describe how all other criteria for ATTC are met.

*If the doctor has denied a HH Referral Request within the previous twelve months:* The service plan may include ATTC services to meet the individual's unmet personal care needs. As the CM, you should work with the individual/family to identify the individual's unmet personal care needs and request an appropriate amount of ATTC hours on the service plan.

### Documentation Requirement:

The Care Manager must enter the following information into a Case Note:

- Name of Physician/PA (Specialty)
- Name Person Who Provided Notification of Denial
- Date Denial Received
- Reason for Denial

Also, in the "Plan Alteration Comment Box", the Care Manager must add the following reference: *"Additional HH PA Information in CN dated XX/XX/XX."*

The documentation should also describe how all other criteria for ATTC are met.

## A referral for HH has been accepted by a Home Health Agency but no services are yet in place

If a referral for HH has been accepted by a Home Health Agency but no services are yet in place, the service plan may request ATTC services to meet the individual's unmet personal care needs. As the CM, you should work with the individual/family to identify the individual's unmet personal care needs and request an appropriate amount of ATTC hours on the service plan.

### Documentation Requirement:

The Care Manager must enter the following information into a Case Note:

- Agency Name
- Agency Contact Name
- Date Agency Contacted
- Date Agency Accepted Referral

Also, in the "Plan Alteration Comment Box", the Care Manager must add the following reference: *"Additional HH PA Information in CN dated XX/XX/XX."*

The documentation should also describe how all other criteria for ATTC are met.

## Home Health Agencies Have Rejected the HH Referral (Can't Find HH Provider)

If a referral for HH has been rejected by at least three Home Health Agencies in the previous twelve months, the service plan may include ATTC services to meet the individual's unmet personal care needs. As the CM, you should work with the individual/family to identify the individual's unmet personal care needs and request an appropriate amount of ATTC hours on the service plan. There is an expectation that the individual/family (assisted by the CM as needed) will reach out to Home Health Agencies on an annual basis.

You can search for home health agencies in your area using the IHCP Provider Locator. Be sure to click the button next to "Other" and select "Home Health Agency." You can then narrow your search by county or zip code.

### Documentation Requirement:

The Care Manager must document three HHA rejections. For each rejection, the Care Manager must enter the following information into a Case Note:

- Agency Name
- Agency Contact Name
- Date Agency Contacted
- Date Agency Rejected Referral
- Reason for Rejection

Also, in the "Plan Alteration Comment Box", the Care Manager must add the following reference: *"Additional HH PA Information in CN dated XX/XX/XX."*

Note regarding HH services in rural areas: If an individual/family is unable to obtain three HHA rejections because there are fewer than three HHA's in their local area, the Care Manager may document fewer than three HHA rejections. However, the care manager must also document the total number of HHA's in the local area.

The documentation should also describe how all other criteria for ATTC are met.