DRAFT

CHAPTER VI

UTILIZATION REVIEW AND CONTROL

CHAPTER VI
TABLE OF CONTENTS

Page

INTRODUCTION 3

PROGRAM INTEGRITY 3

FINANCIAL REVIEW AND VERIFICATION 4

QUALITY MANAGEMENT REVIEW (QMR) OF THE AAL PROVIDER 4

ANNUAL LEVEL OF CARE REVIEWS 6

FRAUDULENT CLAIMS 6
- Provider Fraud 7
- Recipient Fraud 7

REFERRALS TO THE CLIENT MEDICAL MANAGEMENT (CMM) PROGRAM 8

SPECIFIC REQUIRED PROVIDER RECORD DOCUMENTATION 9

MEDICAL RECORDS AND RECORD RETENTION 10

PROVIDER PARTICIPATION STANDARDS 10

PROVIDER SANCTIONS (ADVERSE ACTIONS) 10

PARTICIPATION STANDARDS FOR PROVISION OF SERVICES 12VAC 30-120-1640 11

- Administrators 11
- Licensed Health Care Professional (LHCP) 12
- Structured Activities Program 14
- Direct Care Staff 14
- Training requirements for all staff are as follows: 14
- Documentation 15

INDIVIDUALIZED SERVICE PLAN (ISP) 15

DRAFT

INTRODUCTION

Under the provisions of federal regulations, the Department of Medical Assistance Services (DMAS) must provide for continuing review and evaluation of the care and services paid through Medicaid, including review of health and safety, utilization of the services by providers and by individuals. Title 42 Code of Federal Regulations, Parts 455 and 456, mandates these reviews. DMAS conducts periodic reviews on all programs. In addition, DMAS conducts compliance reviews on providers that are found to provide services in excess of established norms, or based on referrals and complaints from agencies or individuals.

The Virginia Department of Social Services' (VDSS) Division of Licensing Programs is responsible for monitoring each licensed assisted living facility's (ALFs) adherence to VDSS licensure standards which provide the basis for DMAS provider participation standards. In addition, DMAS will periodically conduct audits of services billed to DMAS and interview individuals receiving waiver services to ensure that services are being provided and billed in accordance with DMAS policies and procedures. A provider facility's non-compliance with DMAS policies and procedures will result in a citation for non-compliance or formal retraction of funds depending on the level of non-compliance.

Participating Medicaid providers are responsible for ensuring that requirements for services rendered are met in order to receive payment from DMAS. Under the Participation Agreement with DMAS (see Chapter II), the provider also agrees to give access to records and facilities to DMAS representatives, the Attorney General of Virginia or his authorized representatives, and authorized federal personnel upon reasonable request.

PROGRAM INTEGRITY

DMAS staff from the Division of Program Integrity or a DMAS-designated contractor routinely conducts reviews to ensure that the services provided to individuals who receive Medicaid are medically necessary and appropriate and are provided by a qualified provider. Service providers and individuals receiving care are identified for review by systems-generated exception reporting using various sampling methodologies or by referrals and complaints from agencies or individuals.

DMAS staff or a DMAS contractor review all cases using available resources, including appropriate consultants, and make on-site reviews of medical and other individual and provider records as necessary.

DMAS may use a random sample of paid claims for the audit period to calculate any overpayments or a review of all claims submitted during a specified time period.
Providers will be required to refund payments made by Medicaid if they are found to have billed Medicaid contrary to law or regulation, failed to maintain any record or adequate documentation to support their claims, or billed for medically unnecessary services. In

DRAFT

addition, due to the provision of poor quality services or as a result of any of the above problems, Medicaid may restrict or terminate the provider's participation in the program.

FINANCIAL REVIEW AND VERIFICATION

The purpose of financial review and verification of services is to ensure that the provider bills only for those services that have been provided in accordance with DMAS policy and that are covered under the Virginia Medical Assistance programs and services. Any paid provider claim that cannot be verified at the time of review cannot be considered a valid claim for services provided, and is subject to retraction.

QUALITY MANAGEMENT REVIEW (QMR)

Providers are continuously assessed to assure conformance with VDSS and Medicaid participation standards and policies. VDSS Division of Licensing shall be responsible for monitoring each Alzheimer's Assisted Living (AAL) waiver provider's adherence to licensure standards that provide the basis for DMAS provider participation standards.

The provider is assessed on its ability to render consistent, high-quality care to individuals in need of AAL waiver services. Information used by DMAS to make this assessment may include (i) a DMAS review of documentation submitted by the facility and the case managers from the local public human service agencies; (ii) on-site review of provider files and interviews with staff and with individuals and their families during visits to the AAL facilities; and (iii) responses to compliance and quality management reviews. The DMAS assessment of the provider is based on a comprehensive evaluation of the provider's overall performance in relation to the following program goals:

1. Individuals served by the provider must meet the program's target population. The provider has a responsibility to be aware of the program criteria for AAL Waiver level of care and, on an ongoing basis, to evaluate individuals' appropriateness for services accordingly. The provider must terminate services for any individual whose condition does not meet AAL waiver criteria or contact a public case management agency to perform another assessment to determine whether a change in level of care is warranted;

2. Services being rendered must meet the individual's identified needs, as documented on the Virginia Uniform Assessment Instrument (UAI), admission summary, and must be within the program's guidelines. The provider is responsible for continuously assessing the individual's needs and updating the Individualized Service Plan (ISP);

3. The provider has a responsibility to be aware of the AAL Waiver criteria and to evaluate accordingly, on an ongoing basis, individuals' appropriateness for services. The provider must discontinue services, using the procedures outlined in Chapter IV, for any individual whose condition does not meet the target AAL Waiver population criteria;

DRAFT

4. The provider's documentation must support all days of AAL waiver services billed to DMAS;

5. Services rendered meet the individual's identified needs and are within the program's guidelines. The individual service plan (ISP) is the fundamental tool by which DMAS will ensure the health and welfare of publicly funded services provided to individuals receiving services from the AAL Waiver. The ISP must be revised annually and in accordance with any substantial change in the individual's condition and the individual's record must contain documentation of any such change. The provider is responsible for identifing and making referrals for any other services which the individual requires to remain in the AAL Waiver setting (e.g., durable medical equipment and supplies, home health services, etc.); and

6. Services must be of a quality that meets the health and safety needs and the rights of the individual. Quality of care is best assured through an emphasis on communication and respect between the individual and the provider's staff. Some of the elements included in quality of care are:

   - Consistency of Care: The degree to which the individual receives services consistently from staff familiar with the individual's needs and ISP. The provider should strive to address consistency of care with staff and discuss with individuals and their families ways to minimize the effects of staff turnover.

   - Continuity of Care: The degree to which the individual receives services continuously according to the ISP.

   - Adherence to the ISP: It is the provider's responsibility to provide services according to the amount and type needed and to maintain the proper service as defined in the current ISP. Any difficulties in meeting the ISP must be documented in the individual's record.

   - Health and Safety Needs of the Individual: The provider must identify any health and safety issues and communicate those to appropriate family members, the licensed health care professional and other agencies, etc., as well as follow up to see that these issues get resolved. This includes the provider's responsibility to identify any special needs of the individual and to refer the individual to service providers to meet those needs.

DMAS will review the provider's performance in all the program goal areas to determine the provider's ability to achieve high quality of care and conform to DMAS policies and CMS assurances. A DMAS staff member is responsible for providing technical assistance to the provider regarding those areas which may need improvement. Providers will receive periodic on-site reviews.

DRAFT

During the on-site review process, the DMAS staff will be available to offer technical assistance and consultation to the provider regarding DMAS regulations, policies, and procedures and will communicate in writing with all providers following the on-site review to identify strengths and any areas in which improvement is needed.

Through the assessment and authorization process, DMAS ensures that individuals are placed appropriately in the AAL waiver. Through the ongoing monitoring of the individual's plan of care by the licensed health care professionals, public case managers, and the facility staff, DMAS ensures that all services continue to be needed and the appropriate amount and type of services are provided.

Providers of publicly funded Alzheimer's ALF Waiver services must have written authorization from DMAS or its service authorization contractor in order to bill for AAL Waiver services. Each AAL Waiver provider must have an approved service authorization for each AAL waiver individual for whom DMAS will be billed for services.

ANNUAL LEVEL-OF-CARE REVIEWS

The federal regulations under which waiver services are made available mandates that every AAL Waiver individual receiving services be reviewed each year to assure that he or she continues to meet AAL waiver level of care criteria.

AAL facilities will be required to submit documentation to DMAS each year to show the individual's functional status and medical/nursing needs.

If it is found that an individual no longer meets the level of care for the AAL waiver, DMAS will terminate services in accordance to the procedures detailed in Chapter IV of this manual.

DMAS can require repayment of overpaid money if ALF's continue to serve individuals who do not meet the AAL waiver criteria without notifying DMAS of the change in level of care and the need for discontinuation of services.

FRAUDULENT CLAIMS

Fraud means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him or some other person. It includes any act that constitutes fraud under applicable federal or state law.

Since payment of claims is made from both state and federal funds, submission of false or fraudulent claims, statements, or documents or the concealment of a material fact may be prosecuted as a felony in either federal or state court. The program maintains records for identifying situations in which there is a question of fraud and refers appropriate cases to the Office of the Attorney General for Virginia, the United States Attorney General, or the appropriate law enforcement agency. Further information on submission of fraudulent claims may be found in Chapter II and Chapter V of this manual.

DRAFT

Provider Fraud

The provider is responsible for reading and adhering to applicable state and federal regulations and to the requirements set forth in this manual. The provider is also responsible for ensuring that all employees are likewise informed of the regulations and requirements. The provider certifies by his or her signature or the signature of his or her authorized agent on each invoice that all information provided to DMAS is true, accurate, and complete. Although claims may be prepared and submitted by an employee, providers will still be held responsible for ensuring their completeness and accuracy.

Repeated billing irregularities or possible unethical billing practices by a provider should be reported to the following address, in writing, and with appropriate supportive evidence:

Supervisor, Provider Review Unit
Program Integrity Division
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

Telephone: (804) 692-0480
FAX: (804) 371-8891

Investigations of allegations of provider fraud are the responsibility of the Medicaid Fraud Control Unit in the Office of the Attorney General for Virginia. Provider records are available to personnel from that unit for investigative purposes. Referrals are to be made to:

Director, Medicaid Fraud Control Unit
Office of the Attorney General
900 East Main Street, 5th Floor
Richmond, Virginia 23219

Recipient Fraud

The Recipient Audit Unit of DMAS investigates allegations of fraud or abuse by individuals. The unit focuses primarily on determining whether individuals misrepresented material facts on the application for Medicaid benefits or failed to report changes that, if known, would have resulted in ineligibility. The unit also investigates incidences of Medicaid card sharing and prescription forgeries.

If it is determined that benefits to which the individual was not entitled were approved, corrective action is taken by referring individuals for criminal prosecution, civil litigation, or establishing administrative overpayments and seeking recovery of misspent funds. Under provisions of the Virginia *State Plan for Medical Assistance*, DMAS must sanction an individual who is convicted of Medicaid fraud by a court. That individual will be ineligible for Medicaid for a period of twelve months beginning with the month of fraud conviction.

DRAFT

Referrals should be made to:

Supervisor, Recipient Audit Unit
Program Integrity Division
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

Telephone: (804) 786-0156
FAX: (804) 371-8891

REFERRALS TO THE CLIENT MEDICAL MANAGEMENT (CMM) PROGRAM

DMAS providers may refer Medicaid individuals suspected of inappropriate use or abuse of Medicaid services to the Recipient Monitoring Unit (RMU) of DMAS. Referred individuals will be reviewed by DMAS staff to determine if the utilization meets regulatory criteria for restriction to a primary physician or pharmacy in the Client Medical Management (CMM) Program. If CMM enrollment is not indicated, RMU staff may educate individuals on the appropriate use of medical services, particularly emergency room services.

Referrals may be made by telephone, fax, or in writing. A toll-free HELPLINE is available for callers outside the Richmond area. An answering machine receives after-hours referrals. Written referrals should be mailed to:

Supervisor, Recipient Monitoring Unit
Program Integrity Division
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

Telephone: 1-804-786-6548
CMM HELPLINE: 1-888-323-0589

When making a referral, provide the name and Medicaid number of the individual and a brief statement about the nature of the utilization problems. Hospitals continue to have the option of using the "Non-Emergency Use of the Emergency Room" Referral Form when reporting emergency room abuse. Copies of pertinent documentation, such as emergency room records, are helpful when making written referrals. For a telephone referral, the provider should give his or her name and telephone number in case DMAS has questions regarding the referral.

DRAFT

SPECIFIC REQUIRED PROVIDER RECORD DOCUMENTATION

State regulatory reference to this section may be found in 12VAC30-120-1640.

The assisted living provider must maintain a record for each individual. These records will be reviewed periodically by DMAS) staff for each AAL waiver individual. At a minimum, these records must contain:

- All current and prior UAIs and service authorization forms (Long-Term Care Preadmission Screening Authorization form the DMAS-96) must be in the individual's record;
- The Screening for Mental Illness, Intellectual Disabilitiy, or Related Conditions (DMAS-415) must be in the individual's record to demonstrate evidence of the Alzheimer's or Alzheimer's related Dementia diagnosis;
- Documentation of the participant's approval for the Auxiliary Grant or documentation for each participant who is currently receiving the Auxiliary Grant
- The ISP must be in the individual's record and must be current, appropriate to the individual's needs, and have the appropriate participation of the licensed health care professional (LHCP);
- The LHCP's documentation of their review's and comments must be in each individual's record, this includes all information required for completion of the admission summary documentation;
- All written communication related to the provision of care between the facility and the assessor, case manager, licensed health care professional, DMAS, VDSS, the individual, or other related parties. Staff notes must be in the individual's record promptly after contact is made with the individual. Any relevant contacts not documented and present in the individual's record will be considered as not having been made and may result in retraction of payment;
- A daily log verifying specific dates the individual was actually residing in the ALF for a full 24 hours. The facility must also maintain a log which documents each day the individual is present in the facility. This log should be kept at a central location at the facility. This log must be completed on a daily basis. Leave of Absence Logs (LOAL) which document a individual's absence may not be used in lieu of daily individual logs to document the presence of a individual in the facility;
- LHCP monthly summaries and other required record documentation; and
- All physician orders and documentation of the delivery of ordered medication and/or treatments must be in each individual's record.

DRAFT

MEDICAL RECORDS AND RECORD RETENTION

The provider must ensure the confidentiality of individual record information and provide safeguards against loss, destruction, or unauthorized use. Written procedures must govern record use and removal and the conditions for the release of information. The individual or his/her authorized representative's written consent is required for the release of information not authorized by law. Current individual records and those of discharged individuals must be completed promptly. All clinical information pertaining to an individual must be centralized in the individual's record. All information should meet all established guidelines for the Health Insurance Portability and Accountability Act (HIPAA) compliance and security of records.

The provider must maintain records on all AAL waiver individuals in accordance with accepted professional standards and practice. The records must be completely and accurately documented, readily accessible, legible, and systematically organized to facilitate the retrieval and compilation of information. All AAL Waiver record entries must be fully signed and dated (month, day, and year), including the title (professional designation) of the author.

PROVIDER PARTICIPATION STANDARDS

During the on-site review, the DMAS staff will monitor the provider's compliance with overall provider participation requirements. The provider is responsible for ensuring that all staff of the provider agency met the minimum requirements and qualifications at the start of and throughout the employment. During this review, the staff will discuss with the provider's administration, the provider's overall status as a Medicaid provider, any areas of concern, technical assistance needs and the plans for addressing those needs, and any recommendations the analysts may have. DMAS staff may also require additional documentation to verify that the provider facility is in compliance with DMAS Provider agreements and policies, including requirements for ownership of provider facilities. It is the responsibility of the provider to know and fulfill all applicable state and federal requirements.

PROVIDER SANCTIONS (ADVERSE ACTIONS)

Pursuant to § 32.1-325.1 of the *Code of Virginia*, DMAS is required to collect identified overpayments. Repayment must be made upon demand unless a repayment schedule is agreed to by DMAS. When a lump sum cash payment is not made, interest will be added on the declining balance at the statutory rate pursuant to § 32.1-313.1 of the *Code of Virginia*. Repayment and interest will not apply pending an appeal. The DMAS Fiscal Division will coordinate the collection of any payments due to DMAS.

Repayment schedules must ensure full repayment within 12 months unless the provider demonstrates to the satisfaction of DMAS a financial hardship warranting extended repayment terms.

DRAFT

PARTICIPATION STANDARDS FOR PROVISION OF SERVICES – 12VAC30-120-1640

Facilities must have a signed provider agreement approved by DMAS to provide AAL Waiver services. The ALF must be in good standing and licensed by the VDSS Division of Licensing Programs.

The facility must provide a safe, secure environment for waiver individuals. There may be one or more self-contained special care units in a facility or the whole facility may be a special care unit. Personalized care must be furnished to individuals who reside in their own living units, with semi-private rooms limited to two individuals and bathrooms consistent with 22 VAC40-72-890.

Support in a facility must be furnished in a way that fosters the independence of each individual to age in place. Routines of care provision and service delivery must be individual driven to the maximum extent possible and each individual must be treated with dignity and respect.

The medical care of individuals must be under the direction and supervision of a licensed physician and may be the individual's private physician. The facility must ensure that individuals have appointments with their physicians at least annually, and additionally as needed as determined by the physician.

Administrators

An ALF administrator is defined as the person who oversees the day-to-day operation of the facility, including compliance with all regulations for licensed ALFs. (12VAC30-120-1600)

1. Administrators of participating ALFs must meet the regulatory requirements as set forth by the Virginia Department of Social Services (22VAC40-72-191) and the Board of Long-Term Care Administrators (18VAC95-30).

2. The administrator shall demonstrate knowledge, skills and abilities in the administration and management of an ALF program including:

- Knowledge and understanding of older adults who have impairments or individuals with disabilities;
- Supervisory and interpersonal skills;
- Ability to plan and implement the program; and
- Knowledge of financial management sufficient to ensure program development and continuity.

DRAFT

3. The administrator shall demonstrate knowledge of supervisory and motivational techniques sufficient to:

- Accomplish day-to-day work;
- Train, support and develop staff; and
- Plan responsibilities for staff to ensure that services are provided to individuals.

4. The administrator shall complete 20 hours of continuing education annually to maintain and develop skills. This training shall be in addition to first aid and CPR and orientation training to be received upon commencement of employment.

Licensed Health Care Professional (LHCP)

Each ALF must retain a licensed health care professional, by direct employment, to provide health care oversight for at least 8 hours a day five days a week to its assisted living residents. The VDSS regulations define "licensed health care professional" as any health care professional currently licensed by the Commonwealth of Virginia to practice within the scope of his profession, such as clinical social worker, dentist, licensed practical nurse, nurse practitioner, pharmacist, physical therapist, physician, physician's assistant, psychologist, registered nurse, and speech-language pathologist.

The LHCP must complete an admissions summary of each individual upon admission to the facility and when a significant change in health status or behavior occurs in one of the following areas: weight loss, elopements, behavioral symptoms, or adverse reactions to prescribed medication. A LHCP shall identify individual support needs and formulate interventions, to the extent permitted by his license, to address those problems and to evaluate, to the extent permitted by his license, if the planned interventions were successful. (12VAC30-120-1620)

1. Each facility shall have at least one LHCP awake, on duty, and on-site in the facility for at least eight hours a day, five days each week and the facility shall provide for emergency call coverage at all hours of the day and night.

2. The LHCP is responsible for staff training, individual summaries, individual service plans, and medication oversight.

3. Individuals' summaries.

    a. Admissions summary. An LHCP must complete an admissions summary of each individual upon admission. The admissions summary includes the UAI and other relevant social, psychological, and medical information. The admissions summary must also include the physician's assessment information as contained in 22VAC40-72-40 and 22VAC40-72-440. The admissions summary must be updated yearly and when a significant change

in an individual's health status or behavior occurs. The information gathered during the preparation of the admissions summary is used to create the individual's service plan as contained in 22VAC40-72-40 and 22VAC40-72-440.

b. Individual service plan. Based on the specific individual's admission summary and the UAI, the LHCP, in coordination with other caregivers including the individual's authorized representative, as may be appropriate, shall:

i. Develop the individual's service plan and formulate interventions to address the specific support needs identified;

ii. Evaluate both the facility's implementation and the individual's response to the ISP; and

iii. Review and update the ISP at least quarterly and more often when necessary to meet the needs of the individual.

c. Monthly summary. The LHCP must complete, sign and date the monthly summary document. Significant changes documented on the monthly summary must be addressed in an updated individual service plan. The comprehensive admissions summary information shall also be updated as needed. At a minimum, the monthly summary must include information about the following elements:

i. Weight loss;
ii. Falls;
iii. Elopements;
iv. Behavioral issues;
v. Adverse reactions to prescribed medications;
vi. Dehydration;
vii. Pressure ulcers;
viii. Fecal impaction;
ix. Cognitive changes;
x. The plan of care continues to be appropriate to meet the needs;
xi. Change in diagnoses; and
xii. Change in needs for support with ADLs.

4. The facility's LHCP may also serve as the administrator. In all instances where the facility's LHCP is assigned duties as an administrator, the facility shall assure that the LHCP devotes sufficient time and effort to all clinical duties to secure health, safety, and welfare of individuals.

DRAFT

Structured Activities Program

There shall be a designated employee responsible for managing or coordinating the structured activities program. This employee shall be on site in the special care unit at least 20 hours a week, shall maintain personal interaction with the individuals and familiarity with their needs and interests, and shall meet at least one of the following qualifications:

- Be a qualified therapeutic recreation specialist or activities professional;
- Be eligible for certification as a therapeutic recreation specialist or an activities professional by a recognized accrediting body;
- Have at least one year full-time work experience within the last five years in an activities program in an adult care setting;
- Be a qualified occupational therapist or an occupational therapy assistant; or
- Prior to or within six months of employment, have successfully completed 40 hours of VDSS-approved training.

Direct Care Staff

In order to provide services in this waiver, the assisted living facility must use staff who comply with 22VAC 40-72-250, 22VAC 40-72-1110, and 22VAC 40-72-1120 in staffing the specialty care unit.

The assisted living facility must have sufficient qualified and trained staff to meet the needs of the individuals living in the facility at all times.

Training requirements for all staff are as follows:

1. All staff who have contact with individuals living in the ALF, including the administrator, shall have completed 12 hours of Alzheimer's or related dementia-specific training within 30 days of employment. The training must be conducted by a health care educator, adult education professional, or a licensed professional, with expertise in Alzheimer's or Alzheimer's-related dementia. The health care educator, adult education professional, or licensed professional must be acting within the scope of his profession, have had at least 12 hours of training in the support of individuals with cognitive impairments due to Alzheimer's or related dementia prior to performing the training, and have had a minimum of three years experience in the health care or dementia fields. In addition to health care educators and adult education professionals, licensed professionals eligible to conduct this training may include, but shall not necessarily be limited to, physicians, psychologists, registered nurses, licensed practical nurses, occupational therapists, physical therapists, speech-language therapists, licensed clinical social workers, or licensed professional counselors.

DRAFT

2. All direct support staff must receive annual training in accordance with 22VAC 40-72-250 and 22VAC 40-72-260, with at least eight hours of training in the care of individuals living with dementia and medical nursing needs. This training may be incorporated into the existing training program and must address the medical nursing needs specific to each individuals living in the facility in the special care unit. This training must also incorporate problem areas that may include weight loss, falls, elopements, behavioral issues, and adverse reactions to prescribed medications. A health care educator, adult education professional or licensed professional with expertise in dementia must conduct this training.

Documentation

The assisted living facility shall maintain the following documentation for review by DMAS staff for each individual living in the assisted living facility:

1. All UAIs, authorization forms, individual service plans and admission and monthly summaries and individuals' admissions completed for the individuals living in the facility shall be maintained for a period not less than five years from the waiver individual's start of service in that facility;

2. All written communication related to the provision of services between the facility and the assessor, licensed health care professional, DMAS, VDSS, the waiver individual, or other related parties; and

3. A log that documents each day that the waiver individual is present in the facility.

INDIVIDUALIZED SERVICE PLAN (ISP)

The licensee/administrator or designee, in conjunction with the waiver individual, and the individual's family/authorized representative, case worker, case manager, LHCP, and other health care providers or other persons, as appropriate, shall develop and implement an ISP to meet the individual's service needs. The facility may use the VDSS Model Form/ALF Individualized Service Plan or other facility designated form as long as it meets the requirements of this section.

DMAS requirements for the completion of the ISP are as follows:

- The ISP must be completed by the appropriate parties and maintained in the individual's record; and
- The ISP must be completed in conjunction with the LHCP at least annually or as needed. The LHCP must sign and date the ISP for admission certification purposes and for annual or other updates.

DRAFT

The ISP must include the following:

1. A description of identified need from the UAI, physical examination reports, and any additional assessments necessary to meet the support needs of the waiver individual and date identified;

2. A written description of services to be provided and who will provide them for the individual. The ISP must list the tasks required to meet each service need/objective. Tasks will often involve obtaining a service for the individual. For each service, list the provider/type of staff that will provide the service;

3. When and where the services will be provided;

4. Expected outcomes/goals, including the time frame for accomplishing the measurable objectives. Each identified need should be written as a measurable objective, which is what the ALF and the waiver individual want to achieve for each stated need. Each objective is written in terms of an individual's status that is observable or measurable so that the ALF and the individual will be able to determine when the outcome has been attained. A common error is listing a service rather than an individual status (e.g., improved functioning) as the measurable objective. In order to develop measurable objectives, the ISP must address the following questions:

    a. **What is the support need to be met**? For a case example, the following information is found from administering the UAI to Mrs. Jones:

        - Her lower dentures no longer fit;
        - This limits her food intake;
        - She has lost 10 pounds in 6 months; and
        - She cannot afford to have her dentures fixed.

        The support need statement is that Mrs. Jones is losing weight due to the lack of money to repair her dentures. The support need statement summarizes the identified needs.

    b. **How will staff know if the support need has been met?** The answer to this question should be written in terms of individual status that is observable or measurable so that both parties will be able to tell when the outcome has been attained. Some of the questions to ask are: Will the waiver individual say or do something differently? Will staff be able to observe the individual doing something differently? Will the individual's environment look different?

        In the example above, the measurable objective is: Mrs. Jones will receive new dentures and report eating solid foods regularly. When writing the objective, focus on short-term changes which can be measured and which will lead to long-term resolution of the support need. In the case example,

DRAFT

indicate on the ISP that staff will remove the apparent barrier to Mrs. Jones' ability to eat properly (obtain new dentures) and also state that staff will observe her eating solid food (which will logically lead to improved nutrition and weight gain).

Each outcome should have an expected time frame for accomplishing the measurable objective. Record the full date (month, day, and year) the task will be accomplished. If the task was not accomplished by that date, make a note of the reason.

5. The ISP must be signed by the individual or family/authorized representative, the LHCP, and the licensee/administrator or designee and other persons as appropriate.

DRAFT