

CHOICES

Long-Term Care (LTC) Provider Orientation

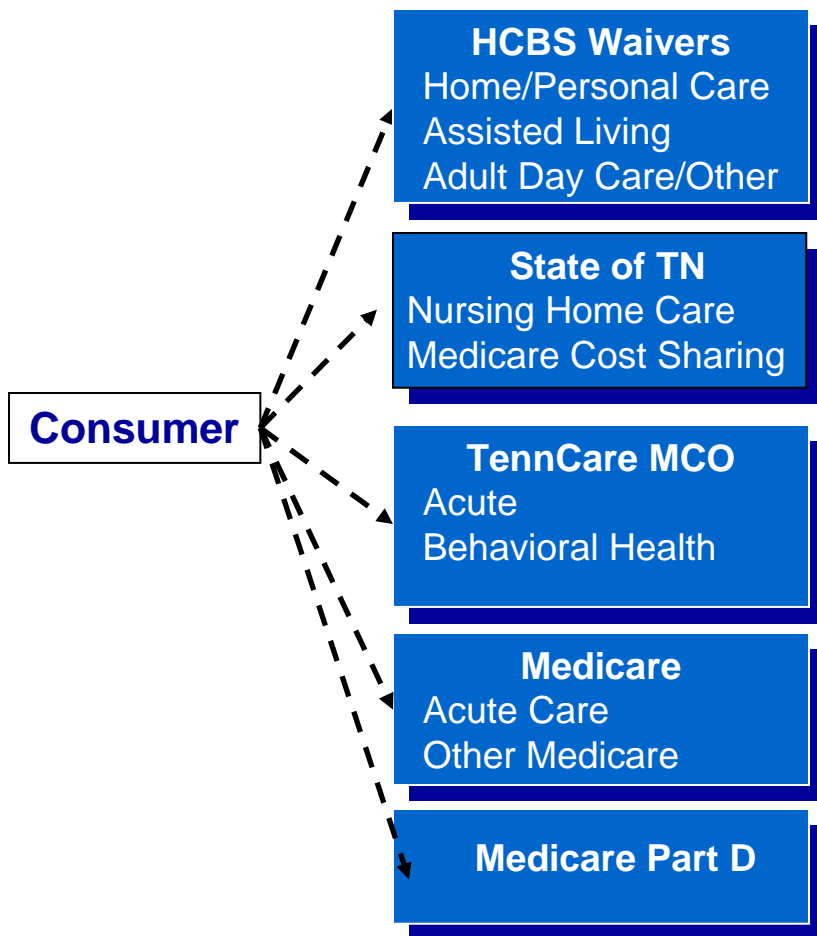


Background: Why CHOICES ?

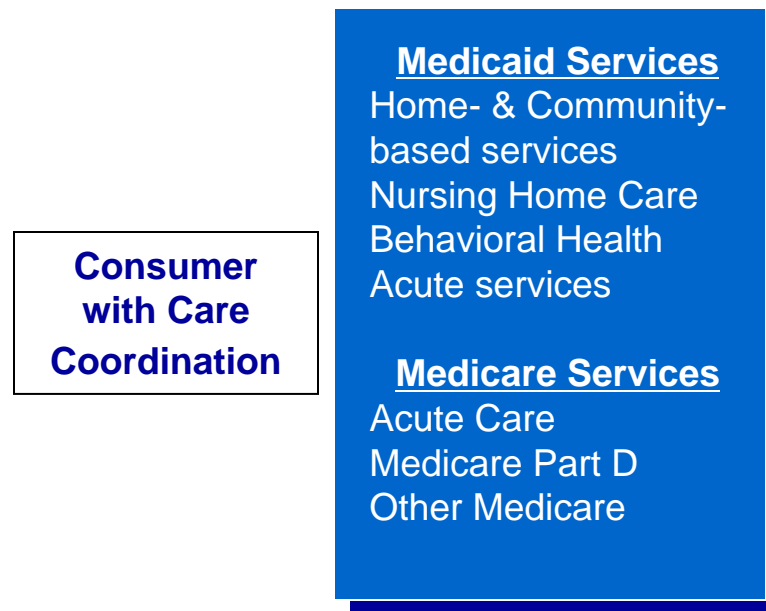
- **Care and services for the elderly and disabled were fragmented.**
- **There was a heavy reliance on Nursing Facilities, and only one community-based residential alternative: Assisted Living Facilities.**
- **98% of LTC spending was for Nursing Facilities**
- **There were few services aimed at preventing or delaying the need for more costly care.**
- **In May 2008, Governor Bredesen signed the Long-Term Care Community Choices Act, with provisions for Home- and Community-Based Services (HCBS).**
- **HCBS includes services for individuals unable to take care of themselves without the assistance of others due to chronic illness, advanced age or cognitive impairment.**
- **Long-term care may be provided at home, in the community or in a nursing facility.**

Integrating Tennessee LTC Services

Current System



TennCare LTC Program



Who does CHOICES serve?

Group	Target Population	Enrollment Target
1	Persons receiving Medicaid-reimbursed NF care All ages and conditions that meet Level of Care (LOC)	Unlimited
2	65/+ or 21/+ with physical disabilities SSI recipients and Institutional eligibles Meet Nursing Facility (NF) Level of Care <i>Receiving HCBS as alternative to NF care</i>	9,500
3	65/+ or 21/+ with physical disabilities SSI recipients Does NOT meet NF LOC, but in the absence of HCBS, is “at risk” of NF placements Implementation is delayed until expiration of Recovery Act dollars—approximately January 2011	750

- If Group 2 Enrollment Target has been met, a request to enroll an individual in a Cost-Effective Alternative may be requested from the Bureau of TennCare.
 - Members who would otherwise receive NF care, if not for HCBS.
- Cost-Effective Alternative may also be requested in the following situations:
 - Non-covered HCBS to Group 2 members.
 - Group 2 or 3 members in excess of the service and benefit limits.

CHOICES Eligibility

Eligibility for CHOICES is based on the following:

- CHOICES Target Populations
- Medicaid Categorical and Financial Eligibility
 - DHS Application
- Medical Eligibility (Level of Care)
 - Pre-Admission Evaluation (PAE)
 - Pre-Admission Screening and Resident Review (PASRR) Regulations (Group 1 Only)
- Safety and Cost Neutrality
- CHOICES Enrollment Targets

Immediate Eligibility for CHOICES:

- Must file Medicaid application first
- 45 days only
- Enrollment only if capacity in Group 2
- Limited package of HCBS only
- If not determined eligible, CHOICES ends in 45 days



Please see the Bureau of TennCare's website for complete eligibility information:
<http://www.state.tn.us/tenncare/>

Enrollment

- Currently enrolled members in TennCare and eligible for CHOICES
 - Enrolled automatically into program
 - Care Coordinator will reach out to member
- New members to TennCare
 - AAAD is the Single Point of Entry (SPOE) for the LTC Choices Program.
- AAAD provides initial assessment and facilitates program eligibility

Pre-Admission Evaluation

Level of Care Assessment
and Reassessment

Needs Assessment
and Reassessment



Pre-Admission Screening and Resident Review

PASRR Level I Screening for MI and/or MR (Intellectual Disabilities)

- Intended to identify persons known or suspected to have mental illness and/or mental retardation.
- PASRR Screening often referred to as Level I PASRR.

Federal Nursing Home Reform Law of 1987, requires that PASRR Screen be completed on all individuals:

- Prior to admission to NF;
- Regardless of payor source; and
- Regardless of the level of reimbursement for NF services:
 - Level 1: Intermediate NF
 - Level 2: Skilled NF

If PASRR Screening is positive, individual referred for PASRR evaluation

- Also known as a Level II PASRR.
- Performed by a contracted independent entity, with final review/determination by the Department of Mental Health and Developmental Disabilities (DMHDD)

LOC Assessment and Reassessment



AAAD will conduct a face-to-face intake visit with the CHOICES applicant to:

- Conduct a level of care and needs assessment
- Assess the member's existing natural support system
- Assess services that may be available at no cost to the member through other entities
- Assess services that are reimbursable through other sources
- Identify the long-term care services and home health and/or private duty nursing services that may be needed by the member that would build upon and not supplant his/her existing natural support system

Needs Assessment and Reassessment

For CHOICES Group 1:

The care coordinator shall:

- assess the member's potential for and interest in transition to the community; and
- ensure coordination of the member's physical and behavioral health and long-term care needs.

For CHOICES Groups 2 & 3:

The care coordinator shall:

- assess the member's physical, behavioral, functional and psychosocial needs;
- conduct an evaluation of the member's financial health as it relates to his/her ability to maintain a safe and healthy living environment;
- ascertain the member's natural supports;
- determine whether there is an anticipated change in the member's need for such care or services, or the availability from the current caregiver or payor;
- assess the physical health, behavioral health, and long-term care services and other social support services and assistance that are needed to ensure the member's health, safety and welfare in the community, and to delay or prevent the need for institutional placement.

Needs reassessments shall be conducted quarterly, or upon change in status.

Enrollee Category/Target

- **Group 1** - Members living in a Nursing Home
 - TennCare has set assessment requirements for members based on length of stay in the facility:
 - > 90 days (180 days – transition member)
 - > 90 days (90 days – new member)
 - < 90 days (90 days – transition member)
 - < 90 days (30 days – new member)
- **Group 2** - Members living in the community (home or assisted living) who are age sixty-five (65) and older, and adults age twenty-one (21) and older with physical disabilities, who meet Nursing Home Level of Care, but are receiving HCBS services
 - Initial assessment will be conducted within 30 days for transition members, and 10 days for new members.

Patient Liability

- The amount of a member's income, as determined by DHS, to be collected each month to help pay for the his/her long-term care services.
- VSHP will be notified by TennCare of patient liability amounts via eligibility/enrollment file.
- The Nursing Facility will collect applicable patient liability amounts. The member may be discharged from the Nursing Facility if the member's liability is not being met. Member may also be disenrolled from VSHP's CHOICES program.

Intake Process for Current VSHP Members

The following may be used to identify members who may be eligible for CHOICES:

- Referral from member's Primary Care Provider, specialist, or other provider
- Self-referral by member, or referral by member's family or guardian
- Referral from VSHP staff
- Notification of hospital admission
- Claims or encounter data
- Hospital admission or discharge date
- Pharmacy data
- Data collected through the disease management or utilization management processes



Long-Term Care Services Available

- Benefit Limits
- Cost Neutrality Cap
- Expenditure Cap



Current HCBS Services

Adult Day Care	A place where the member may go during the day to spend time with others.
Community-Based Residential Alternative (CBRA)	A place where the member may live that will help them with personal care needs, homemaker services, and taking medicines correctly. *Medicaid cannot pay for their room and board.
Assistive Technology	Certain devices that will help the member with Activities of Daily Living, such as grabbers or large handled eating utensils.
Attendant Care	Someone to help with member's Activities of Daily Living for longer periods of time, or to go with the member to doctor's visits or other appointments.
Home Delivered Meals	One healthy meal per day delivered to the member's home.
Homemaker	Someone to help member with household chores or errands like laundry, sweeping or grocery shopping.
In-Home Respite	Someone to come and stay with the member in his/her home for a short time so his/her caregiver may get some rest.
Inpatient Respite	Short stay in a nursing home or assisted care living facility so the member's caregiver may rest.
Minor Home Modifications	Certain devices or changes to the member's home to make it easier and safer for him or her to be in the home, such as ramps or grab-bars.
Personal Care	Someone to help the member with Activities of Daily Living such as bathing, dressing, preparing and eating meals, toileting or transfers.
Personal Emergency Response System (PERS)	A call button the member wears that works through the telephone, so he/she may call for help in an emergency.
Pest Control	Someone to come to the member's home a few times a year to spray for bugs or get rid of mice and rats.

Benefit Limits

Group	Services	Service Limits	Unit
1	NF Care	N/A	Day
	SNF Care		Day
2	NF Care	Short-term only (up to 90 days)	Day
	CBRA	N/A	
	Personal Care	2 visits per day	15 minutes
	Attendant Care	1,080 hours per calendar year	15 minutes
	Homemaker Services	3 visits per week	15 minutes
	Home-delivered Meals	1 meal per day	Meal
	PERS-Installation	1 unit	1 unit
	PERS-Monthly Fee	12 months per year	Month
	Adult Day Care	2,080 hours per calendar year	15 minutes
	In-home Respite Care	216 hours per calendar year	15 minutes
	In-Patient Respite Care	9 days per calendar year	Day
	Assistive Technology	\$900 per calendar year	1 Device
	Minor Home Modifications	\$6,000/project; \$10,000/calendar year; and \$20,000/lifetime	N/A
	Pest Control	9 units per calendar year	Visit

New Community-Based Residential Alternatives (CBRAs)

Critical Adult Care Homes

- 24-hour residential care in a homelike environment for no more than five elderly or disabled adults.
- Level II – Specialized and/or Skilled Services for Ventilator Care and Traumatic Brain Injury.
- Continuum Model – Allows members to age in place.

Companion Care

- Live-in caregiver hired and supervised by the member (consumer direction)



Consumer-Directed Options in CHOICES

■ **Consumer Direction**

- **Allows consumers to select, direct and employ caregivers**
 - Personal Care
 - Attendant Care
 - Homemaker
 - In-Home Respite
 - Companion Care

■ **Self-Direction of Health Care Tasks**

- **Allows members who elect to employ workers for specified services to also direct and supervise workers in the performance of certain health care tasks**
 - Initially limited to administration of oral, topical and inhaled medications
 - Limited to consumer-directed workers

Cost Neutrality Formula

Annual Individual Cost Cap

$$\boxed{\begin{array}{c} \text{Annual} \\ \text{cost of} \\ \text{all} \\ \text{HCBS} \end{array}} + \boxed{\begin{array}{c} \text{Annual cost of} \\ \text{home health} \\ \text{or private duty} \\ \text{nurse} \end{array}} \leq \boxed{\begin{array}{c} \text{Average annual cost} \\ \text{of care in a NF} \end{array}}$$

- Cost Neutrality Cap is based on the average annual cost of the level of NF reimbursement that would be paid if the member was in a NF.
 - Level I NF Average – \$144.42/day; Rounds to \$52,000/year
 - Level II SNF Average – \$151.95/day; Rounds to \$55,000/year
 - Enhanced add-on SNF rates – Higher Payment for specific care (i.e., vent)
- The averages are based on cost reports and determined by the Office of the Comptroller
 - Adjusted annually

Service Authorization Requirements and Processes

Service Authorizations shall include the amount, frequency, and duration of each service to be provided and the schedule at which such care is needed.



Roles and Responsibilities of the Care Coordinator (CHOICES Group 1)

For members receiving services in a nursing facility:

- Conduct a face-to-face visit
- Do needs assessment if deemed necessary
- Review plan of care
- Supplement plan of care as necessary

For members waiting placement in nursing facility:

- Conduct face-to-face visit
- Perform additional needs assessment if deemed necessary
- Upon member's entry into nursing facility, participate in care planning process



Roles and Responsibilities of the Care Coordinator (CHOICES Groups 2 and 3)

- Conduct a face-to-face visit with member
- Develop a plan of care
- Authorize and initiate additional Home- and Community-Based Services as needed
- Review and revise as necessary member's risk assessment and risk agreement
- Have member or representative sign any revised risk agreement
- Provide education regarding choice of contract providers for HCBS
- Obtain signed confirmation of member's choice of contracted providers

Please Note: Members enrolled on the basis of Immediate Eligibility shall have access to a limited package of HCBS pending determination of categorical and financial eligibility for TennCare CHOICES. All needed services will be listed in the plan of care for immediate authorization if determined eligible for CHOICES.

Roles and Responsibilities of Long-Term Care & Other Providers

- Agree that VSHP may monitor quality of services delivered under the provider agreement.
- Comply with corrective action plans if needed to improve quality of care.
- Submit reports and clinical information in a timely manner as needed.
- Provide name and address of official payee.
- Make full disclosure of the method and amount of compensation to be received from VSHP.
- Be responsible for ensuring any applicable authorization requirements are met and verifying the person is eligible for TennCare on the date of service.
- Provide for prompt submission of information needed to make payment (usually within 120 calendar days from the date of rendering a covered service).
- Accept payment or appropriate denial made by VSHP, and not solicit or accept any surety or guarantee of payment from the member in excess of the amount of applicable TennCare cost-sharing responsibilities.

Roles and Responsibilities Cont.

- Identify third-party liability coverage, including Medicare and long-term care insurance as applicable, and bill them first.
- Report suspected fraud or abuse of TennCare.
- Report suspected abuse, neglect and exploitation of adults, and suspected brutality, abuse or neglect of children.
- Report any known significant changes in the member's condition or care, hospitalizations or recommendations for additional services.
- Conduct background checks in accordance with state law and TennCare policy.
- Recognize and abide by all applicable state and federal laws, regulations and guidelines.
- Safeguard information about members according to state and federal laws and regulations.
- Display notices of the member's right to appeal adverse action affecting services in public areas of your facility, as applicable.

Plan of Care

For members in CHOICES Group 1:

- Care coordinator may rely on the plan of care developed by the nursing facility for service delivery and supplement as necessary.

For members in CHOICES Groups 2 and 3:

- Care coordinator may seek input from member or representatives approved by member to assist with needs assessment.
- Care coordinator will consult member's PCP, specialists, behavioral health providers, other providers and interdisciplinary team experts, as needed, to develop plan of care.

Plan of care will include:

- Pertinent demographic information regarding member.
- Name and contact information of any authorized representative.
- List of other persons authorized to have access to health care information.
- Care, including specific tasks and functions performed by family members and other care givers.
- Home health, private duty nursing, and long-term care services the member will receive from other payor sources, including the payor information.
- Home health and private duty nursing authorized by VSHP.
- HCBS authorized by VSHP, including the amount, frequency, duration and scope of each service to be provided and the schedule at which the care is needed.

Please Note: Members enrolled on basis of Immediate Eligibility shall have access only to a limited package of HCBS pending determination of categorical and financial eligibility for CHOICES.



Electronic Visit Verification System

- Provider staff and consumer-directed workers will check in at the beginning, and check out at the end of each period of service delivery to monitor member receipt of HCBS.
- Will be utilized for claims submissions for HCBS.
- Will aid Care Coordinators in monitoring delivery of services and allow for immediate action as needed.
- Additional training and information about the Electronic Visit Verification System is available upon request.

Please Note: Pest Control Services will not utilize EVV.

Staff Background Check Requirements

- Providers must screen their employees and contractors initially, and on an ongoing monthly basis to determine whether any of them has been excluded from participation in Medicare, Medicaid, SCHIP or any federal health care programs.
- Do not employ or contract with an individual or entity that has been excluded.
- Immediately notify VSHP of any exclusion information discovered.

Background Check Requirements for Nursing Facilities

Please continue to perform background checks as required by Health Care Facilities, CMS, and Licensure Surveys.



SXC Solutions

- Many injectable medications are available via SXC Solutions for the TennCare Pharmacy Program.
- For prior authorization or to request an override for quantity limit, please contact SXC at:
 - Pharmacy Helpdesk: 1-866-434-5520
 - Clinical PA Line: 1-866-434-5524
 - Clinical PA Fax: 1-866-434-5523
- Website: <https://tnm.rxportal.sxc.com/rxclaim/portal/preLogin>

Prohibition to Balance Bill Members

- May only bill members for their allowed cost-sharing responsibilities.
- May **NOT** bill members for:
 - missed appointments
 - primary insurance deductibles and copayments
 - emergency services
- The Tennessee prohibition is found at Rule 1200-13-13-.08 and 1200-13-14-.08.
- The federal law prohibition is found at 42 U.S.C.A. § 1395cc and 42 U.S.C.A. §1396a(p).

Medicaid Program Integrity

VSHP Policy provides information about a number of federal and state regulations that govern information provided to the government, including:

- Federal False Claims Act
- State False Claims Acts; and
- other regulations and protections.

Provider Compliance

- **Title VI of the Civil Rights Act of 1964**
 - Covered entities have an obligation to provide oral and written language assistance to limited English proficiency (LEP) persons
 - Language and Translation Services
- Review checklist of compliance items for providers available on our websites: vshptn.com and bcbst.com

HIPAA Compliance

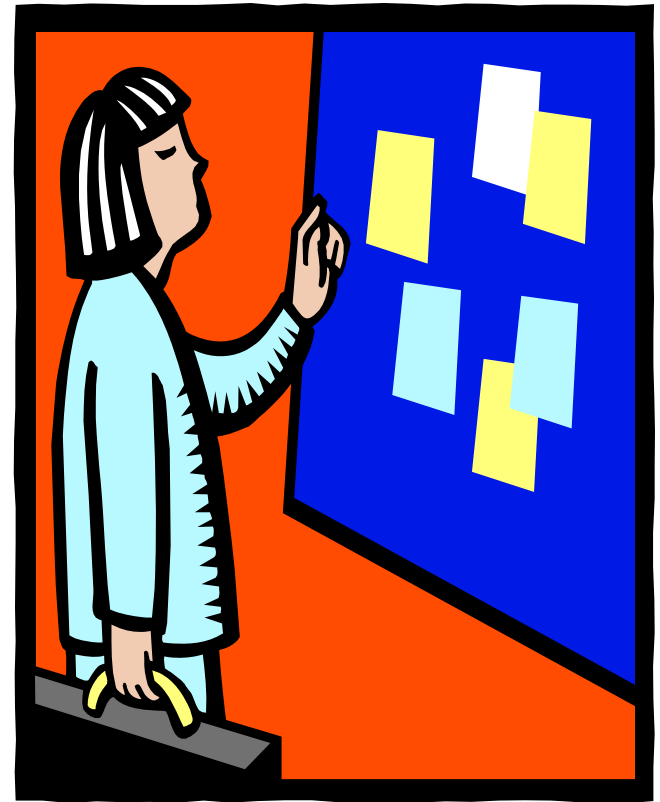
- Providers must abide by all laws and regulations with respect to confidentiality and information security
- Providers must share member information with BCBST/VSHP
- Providers should notify the BCBST Compliance Officer within 24 hours of a breach in member patient health identifiable information (PHI)

Member Complaint and Appeal Processes

- TennCare members have the right to appeal any adverse actions taken by the Health Plan.
- A Member Advocate is available to assist members with the appeal process, including completing paperwork and helping facilitate a resolution.
- The TennCare program requires that providers comply with the appeal process.

Grier Consent Decree

Enforces rights of TennCare enrollees, and specifies that all TennCare providers must display notices of the right to appeal adverse decisions affecting services in a public area of their office.



Special Needs Accommodations

Covered entities **must not**:

- Establish eligibility criteria that screen out individuals
- Provide separate or different benefits, services or programs

Covered entities **must**:

- Provide services and programs in the most integrated setting appropriate
- Make reasonable modifications in their policies, practices and procedures
- Ensure that buildings are accessible
- Provide auxiliary aids to individuals with disabilities, at no additional cost, where necessary

Information About Abuse and/or Neglect

- Suspected abuse, neglect and exploitation of members who are adults must be immediately reported in accordance with TCA 71-6-103 to **1-888-APS-TENN (1-888-277-8366)**.
- Suspected brutality, abuse or neglect of members who are children must be immediately reported in accordance with TCA 37-1-403 or TCA 37-1-605, as applicable, to **1-877-237-0004 or 1-877-54ABUSE (1-877-542-2873)**.
- You should also notify VSHP/BCBST of the suspected abuse and/or neglect within 24 hours.



Critical Incident Reporting and Management

HCBS

Critical incidents shall include, but not be limited to, the following incidents when they occur in a home- and community-based long-term care services delivery setting:

- Unexpected death of a CHOICES member
- Suspected physical or mental abuse of a CHOICES member
- Theft from or financial exploitation of a CHOICES member
- Severe injury sustained by a CHOICES member
- Medication error involving a CHOICES member
- Sexual abuse and/or suspected sexual abuse of a CHOICES member
- Abuse and neglect, and/or suspected abuse and neglect, of a CHOICES member

Long-Term Care/Nursing Facilities

- Report any suspected abuse and/or neglect of a CHOICES member.

Provider Complaint System Procedure

1. Inquiry/Consideration

Providers should contact VSHP if there is a dispute concerning claims, authorization or other issues within the provider and VSHP's control.

2. Appeal

If not satisfied, a written appeal may be submitted within 30 days after receiving the other party's response to its inquiry/reconsideration.

3. Mediation

A party may request mediation by submitting a written request within 30 days of receipt of the other party's appeal response.

4. Binding Arbitration

Either party may make a written demand for binding arbitration within 30 days after it receives a response to its appeal or the conclusion of the mediation of that dispute.

Note: Please refer to the **VSHP Provider Administration Manual** for the appropriate forms.

How to Submit Clean Claims

HCBS

- The Electronic Visit Verification (EVV) System will create an electronic claims submission file which will be submitted to VSHP for claims processing.
- Claims will be processed and paid within 14 days of receipt.
- No paper claims will be accepted
- Claims are time-limited to 120 days.

Long-Term Care Facility

- Work with Provider Relations Staff to handle claims like other institutional claims.
- Paper claims may be submitted
- Contracted and non-contracted providers must submit all claims for medical services within 120 days of the date of service.
- Facilities claims must be submitted within 120 days from the date of discharge.
- The provider administration manual has additional tips for completing claims under Section V, Billing and Reimbursement.