CHOICES Long-Term Care 2010

Home & Community-Based Services (HCBS)

Who We Are

- VSHP is a wholly-owned subsidiary of BlueCross BlueShield of Tennessee (BCBST)
- BCBST covers 2.4 million lives
  - Tennessee's oldest and largest insurer
- VSHP was the first TennCare Managed Care Organization (MCO), established in 1994
  - Administers BlueCare and TennCare*Select*
  - Covers 500,000 lives statewide

VSHP Volunteer State Health Plan

Mission Statement

"To be the national expert for state governments seeking innovative partners to develop health care solutions for the nation's most vulnerable populations."

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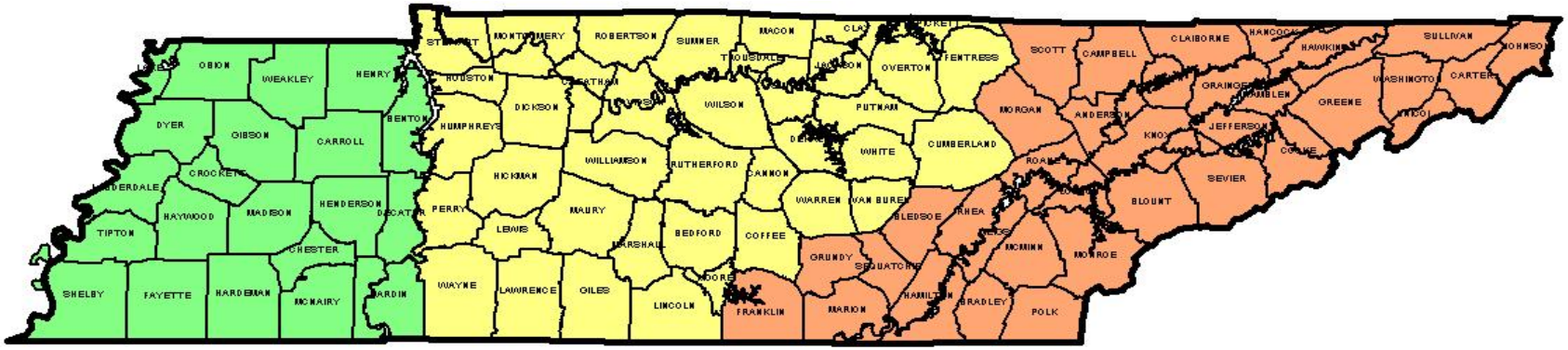
Grand Regions by MCO



West Tennessee	
AmeriChoice	Benton, Carroll, Chester, Crockett, Decatur, Dyer, Fayette, Gibson, Hardeman, Hardin, Haywood, Henderson, Henry, Lake, Lauderdale, Madison, McNairy, Obion, Shelby, Tipton, Weakley
BlueCare	
TennCare*Select*	
Middle Tennessee	
AmeriChoice	Bedford, Cannon, Cheatham, Clay, Coffee, Cumberland, Davidson, DeKalb, Dickson, Fentress, Giles, Hickman, Houston, Humphreys, Jackson, Lawrence, Lewis, Lincoln, Macon, Marshall, Maury, Montgomery, Moore, Overton, Perry, Pickett, Putnam, Robertson, Rutherford, Smith, Stewart, Sumner, Trousdale, Van Buren, Warren, Wayne, White, Williamson, Wilson
AmeriGroup	
TennCare*Select*	
East Tennessee	
AmeriChoice	Anderson, Bledsoe, Blount, Bradley, Campbell, Carter, Claiborne, Cocke, Franklin, Grainger, Greene, Grundy, Hamblen, Hamilton, Hancock, Hawkins, Jefferson, Johnson, Knox, Loudon, Marion, McMinn, Meigs, Monroe, Morgan, Polk, Rhea, Roane, Scott, Sequatchie, Sevier, Sullivan, Unicoi, Union, Washington
BlueCare	
TennCare*Select*	

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Single Point of Entry (SPOE)

Area Agencies on Aging and Disability (AAADs)

- One access point for new Medicaid applicants seeking access to HCBS services
- Public Education and Outreach
- Information and Referral
- Screening and Assessment
- Facilitate Eligibility and Enrollment
- Completion and Submission of Pre-Admission Evaluations (PAEs)
- Credentialing of HCBS Providers

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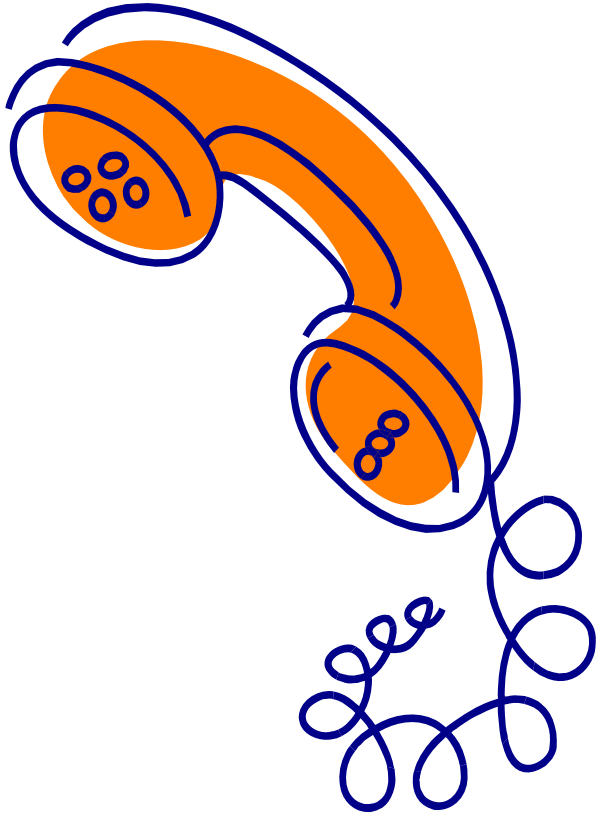
AAAD/SPOE Toll-Free Number

- **For people who do not already have Medicaid, this is the number they may call to speak with someone who can tell them more about CHOICES.**
  - **1-866-836-6678**
  - **OR, you may call the local AAAD**



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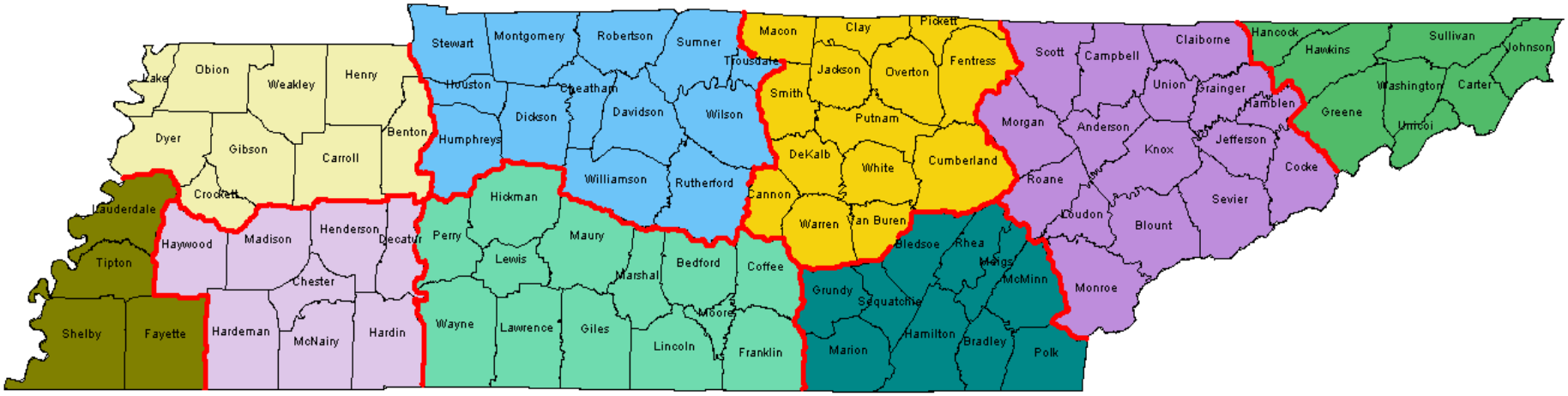
Tennessee AAAD's



Area	Name	Address	City	State	Zip	Phone	Fax
1	First TN Dev. District	207 North Boone Street Suite 800	Johnson City	TN	37604	423-928-0224	423-928-5209
2	East TN Human Resource Agency	9111 Cross Park Drive, Suite D100	Knoxville	TN	37923	865-691-2551 ext. 216	865-531-7216
3	Southeast TN Dev. District	1000 Riverfront Parkway	Chattanooga	TN	37402	423-266-5781	423-424-4225
4	Upper Cumberland Dev. District	1225 South Willow Ave.	Cookeville	TN	38506	931-432-4111	931-432-6010
5	Greater Nashville Regional Council	501 Union Street, 6th Floor	Nashville	TN	37219	615-862-8828	615-862-8840
6	South Central TN Dev. District	815 South Main Street	Columbia	TN	38402	931-381-2040	931-381-2053
7	Northwest Dev. District	124 Weldon Drive	Martin	TN	38237	731-587-4213	731-588-5833
8	Southwest TN Dev. District	27 Conrad Drive, Suite 150	Jackson	TN	38305	731-668-7112	731-668-6438
9	Aging Commission of the Mid-South	2670 Union Avenue Extended, Suite 1000	Memphis	TN	38112	901-324-6333	901-327-7755

VSHP Volunteer State Health Plan

Care Coordination **(CC)**

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What Happens When CHOICES is Implemented?

- Notice provided to both transitioning groups
  - HCBS waiver participants and
  - Nursing Facility (NF) residents
- No right to fair hearing or to remain in fee-for-service LTC
- No MCO change option associated with CHOICES implementation
- Assignment of a care coordinator prior to first face-to-face visit (regardless of CHOICES group)
- If face-to-face visit will not occur within 10 days following CHOICES implementation, MCO must issue written notice to member regarding how to contact Care Coordination Unit

What Happens when CHOICES Is Implemented? (Cont.)

- **30-day minimum continuity of care period**
  - Based on currently authorized Waiver plan of care
  - Member continues to receive type, amount and frequency of services (except case management)
  - Member continues with same providers (contract or non-contract)
  - Continuity of Care (COC) period extended until Comprehensive Needs Assessment and new Plan of Care are complete
  - Non-contract providers reimbursed at full contract rate during COC period

Transition of Current Waiver Participants

- Initial face-to-face visit completed within 90 days following CHOICES implementation
  - Comprehensive Needs Assessment and new Plan of Care
  - Services in new Plan of Care authorized and initiated
- Until complete, services may be *increased* if a member's needs/circumstances change, but not *reduced*
- Any reduction or change in type, amount, frequency or duration of waiver services to implement new Plan of Care requires *Grier* notice of action
- Care Coordination facilitates transition to new services and/or providers in new Plan of Care

Care Coordination in CHOICES

- Comprehensive, continuous, holistic and person-centered approach to care coordination
  - Help the member maintain or improve physical or behavioral health status or functional abilities
  - Maximize member independence
  - Ensure member's health, safety and welfare
  - Delay or prevent the need for institutional placement
- Integrated model of coordination of care – medical as well as social
- Addresses physical, behavioral, functional Activities of Daily Living (ADL) and psychosocial needs
- Coordinates ALL Medicaid services for the elderly and disabled – physical, behavioral and long-term care

Critical Incident Reporting

Critical incidents shall include—but not 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 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.

Critical Incidents should be reported to VSHP Care Coordination immediately upon discovery.

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CHOICES Toll-Free Number For Care Coordination

1-888-747-8955

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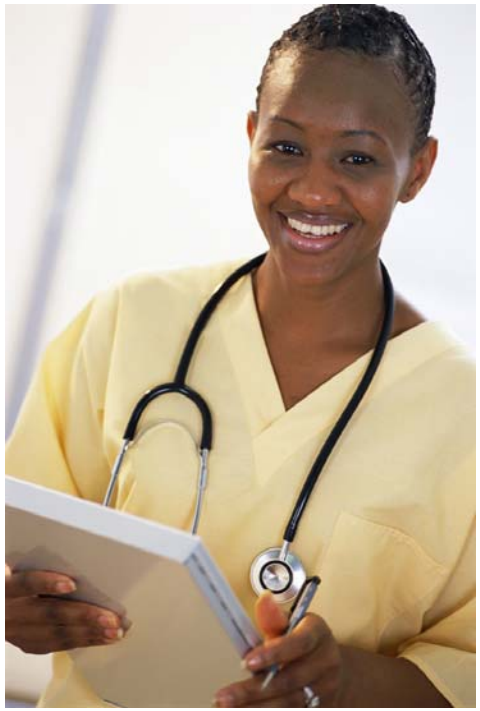
Nurseline

VSHP members may speak to a Registered Nurse (RN) anytime – 24-hours-a-day, 7-days-a-week - with 24/7 Nurseline:

1-800-262-2873



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Billing

VSHP
Volunteer State Health Plan

Submitting Clean Claims

- **The Electronic Visit Verification (EVV) System will create an electronic claims submission file which may be submitted to VSHP for claims processing.*****
- **90% of clean electronic claims will be processed and paid by the MCO within 14 calendar days of receipt. 99.5% will be paid within 21 calendar days.**
- **Claims submitted must include the Provider's Tax ID number, the National Provider Identifier and the required data elements.**
- **Paper Claims may be submitted as UB-04 claims**
- **Contracted and non-contracted providers must submit all claims for medical services within 120 days of the date of service.**
- **The provider administration manual has additional tips for completing claims under Section V: Billing and Reimbursement. Accessible on www.vshptn.com**

*** ***Pest Control providers will not use EVV for claims submission***

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Electronic Visit Verification (EVV)

- EVV System required for CHOICES HCBS only
  - Tracks the provision of certain HCBS
  - Facilitates timely payment
  - Increases ability to detect and resolve problems
    - Service gaps
    - Delays in service delivery
- Log-in/Log-out by phone
- In-depth training for HCBS providers upon request

EVV System Requirements

- Internet Access (DSL or faster preferred)
- Microsoft Windows XP, Vista
- IE Explorer version 7.x or 8.x or Firefox 3.5x
- Video Card that supports 1024 x 768, 16-Bit
- Pentium D 2GHz processor or better
- 1GB of RAM or better (2GB of Ram for Vista)
- 1GB free hard-disk space

* No special software needed

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Claims Submission

EVV

- Adult Day Care
- Attendant Care
- Companion Care
- Home Delivered Meals
- Homemaker Services
- In-Home Respite
- Personal Care

Electronic Clearing House

- Assisted Care Living Facilities
- Assistive Technology
- Critical Adult Care Homes
- Minor Home Modifications
- Nursing Facilities
- Personal Emergency Response Systems (PERS)
- Pest Control

Paper Claims

Claims Service Center
1 Cameron Hill Cr, Ste 0002
Chattanooga, TN 37402-0002

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Electronic Billing Contact

Contact eBusiness Solutions:

- www.bcbst.com/providers/ecomm/
- 1-800-924-7141
- ecomm_contracts@bcbst.com

- Once the Electronic Provider Profile has been completed, you will receive a letter with your username and temporary password to connect to EC Gateway to retrieve Timely Filing Reports, and Reject Reports.

VSHP Volunteer State Health Plan

Submitting Claims to VSHP

An adjustment has been made to the way claims will be submitted to Volunteer State Health Plan (VSHP) when using the Electronic Visit Verification (EVV) system. Sandata will now be submitting all EVV providers' claims to VSHP via secure File Transfer Protocol (FTP) connection.

You are no longer required to have a dial-up modem **UNLESS** you would like to receive Proof of Timely Filing and Reject Reports, **THEN** you will be required to obtain a dial-up modem.

In addition, providers may register for BlueAccess on our website, www.bcbst.com. BlueAccess enables you to view information in a secure, online environment, just as it appears right now in our customer service computer system, along with viewing remittance advices.

VSHP Volunteer State Health Plan

Creating Your Invoice

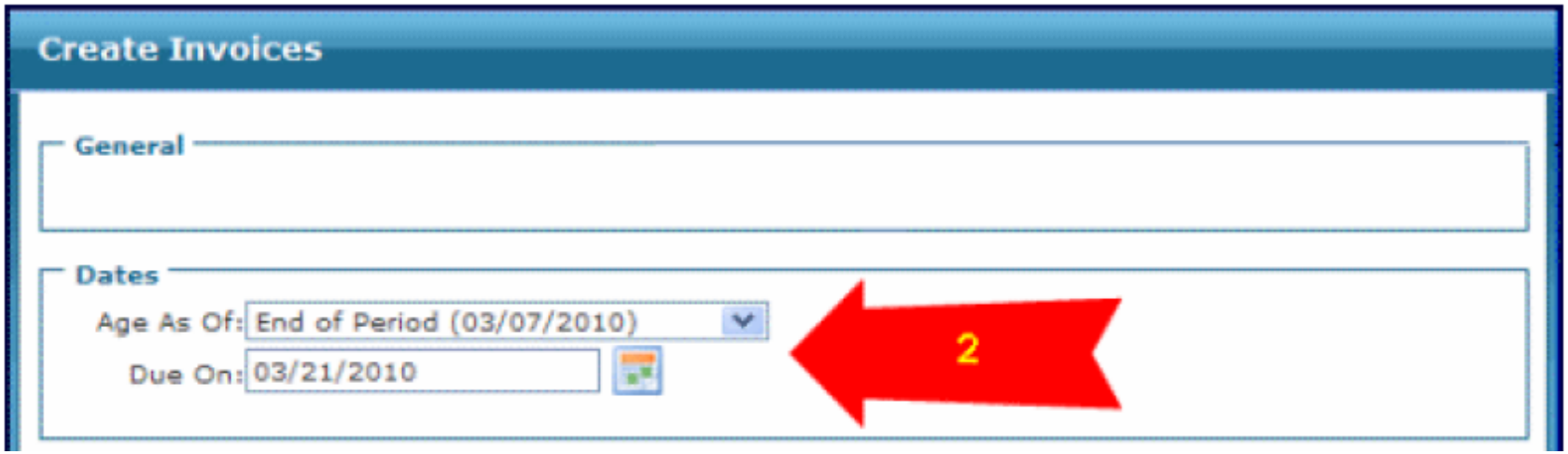
Follow the instructions provided by Sandata on creating your claims invoice.

1. Click on **Create Invoices,** located towards the top right corner of the screen.

Volunteer State Health Plan

Creating Your Invoice (Cont.)

2. Review the Dates information. Age As Of date is the invoice date. Sandata suggests it be the day you create the invoices. It is recommend you export the claims on the same day, which allows you to easily see the date of the export.



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Creating Your Invoice (Cont.)

3. Check the *Print A Summary Report* checkbox if you would like to save a summary report of the invoices created.
4. Click on **Create Invoices.**
5. The Billing screen will clear, and you are ready to export the claims.
6. If anything remains on the billing review screen, it must be researched and resolved.

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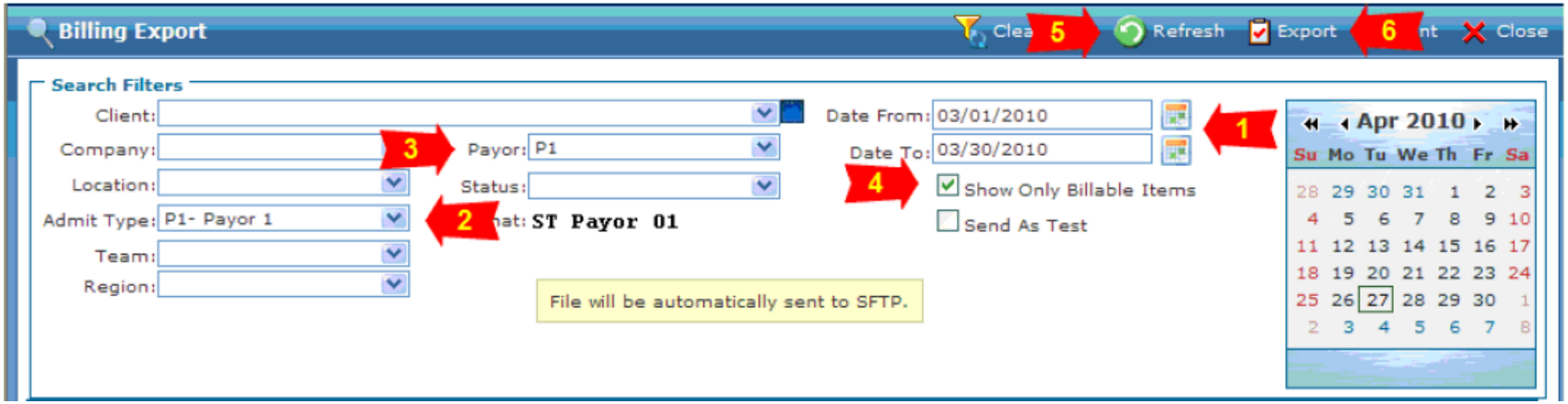
Billing Export

Click the Billing → **Export** button



Select a Date Range (That range should never be greater then the current date).

1. Select an **Admit Type**.
2. Select a **Payor** (Admit Type and Payor must match).
3. Check the **Show Only Billable Items** checkbox. (These are the items ready to be exported.)
4. Click on **Refresh.**
5. Click on **Export.**

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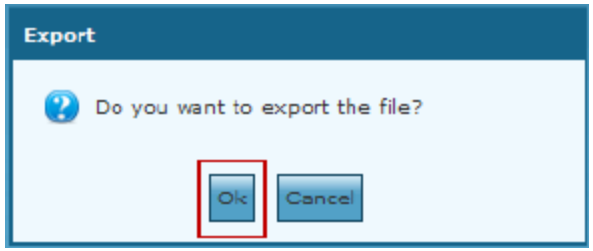
Billing Export (Cont.)

7. Click on **OK.**
8. You will be prompted that your export was successful.



Creating a Report Folder

Please follow the steps outlined in the following slides to setup your dial-up modem and hyper terminal connection to retrieve reports regarding timely filing and rejections.

Report Folder

- Right Click on Desktop, Select **New Folder**
- Name Folder **BCBST Reports**

Note: *If your company has a shared drive on a server, you might want to create these folders there or in another location. Where the folders reside is up to the individual establishment, as long as everyone knows where they are, and the information can be backed up.*

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Creating your Hyper Terminal Connection

Call (423) 535-5717 for assistance

You will need:

- **Dial-up Modem**
  - Phone Line (this does not have to be a designated line).
- **HyperTerminal**
  - HyperTerminal is a tool that lets you connect to other computers, Internet telnet sites, bulletin board services, online services, and host computers, using either your modem or a null modem cable.
- **User Guide is available at**

  www.bcbst.com/providers/ecomm/technical-information.shtml

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Timely Filing/Reject Reports

- Within two business days, you will receive a **Confirmation Report**. *This is your proof of timely filing*.
  - This report also gives you a claim-by-claim accounting.
    - If the claim is accepted, it will be sent for adjudication. If it rejects, there will be a claim number assigned, and you will need to call the eBusiness Service Center for explanation.

Please note: The only way to retrieve this report is to connect to BCBST using a dial-up modem.

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E-Comm Rejections

ALL REJECTIONS WILL NEED TO BE FIXED BY SANDATA AND RESUBMITTED

- If you receive a rejection on either your 997 report or Confirmation Report, please call the eBusiness Service Center for an explanation.

- Once you receive the explanation, please contact Sandata Technologies at 1-877-526-0516.

Electronic Billing Contact

Contact eBusiness Solutions:

www.bcbst.com/providers/ecomm/

1-800-924-7141

ecomm_contracts@bcbst.com

VSHP Volunteer State Health Plan

Provider Roles & Responsibilities

- 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 timely 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 shall not solicit or accept any surety or guarantee of payment from the member in excess of the amount of applicable TennCare cost sharing responsibilities.

Provider Roles & Responsibilities Continued

- 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 state and federal laws, regulations and guidelines applicable.
- Safeguard information about members according to state and federal laws and regulations.
- Display notices of the member's right to appeal adverse action affective services in public areas of your facility, as applicable.

Credentialing

- Current credentialing requirements for HCBS providers will not change
  - AAAD Verification
  - Annual review
- Part of the Contracting process
  - ALL providers must be credentialed in order to participate in the VSHP network
  - Process by which VSHP verifies that providers meet all applicable state and federal provider qualifications
- Liability Insurance exception for Nursing Facilities
  - Nursing Facilities who contract to provide HCBS services are not required to carry additional liability insurance as a condition of providing HCBS services

Provider Complaints

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 at the conclusion of the mediation of that dispute.

Please refer to the VSHP Provider Administration Manual for the appropriate forms on www.vshptn.com.

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For More Information About the DHS Application

- www.tn.gov/humanserv/forms/hs-0169.pdf
  - DHS Application (12 pages)
  - Instructions

- www.tn.gov/humanserv/adfam/afs_med.html
  - Information about Medicaid/TennCare
  - Online DHS Application

For More Information About the PAE

- www.tn.gov/tenncare/forms/memotopaeform.pdf
  - PAE Form
  - Memo
  - Checklist

Provider Relations Contacts

East Grand Region

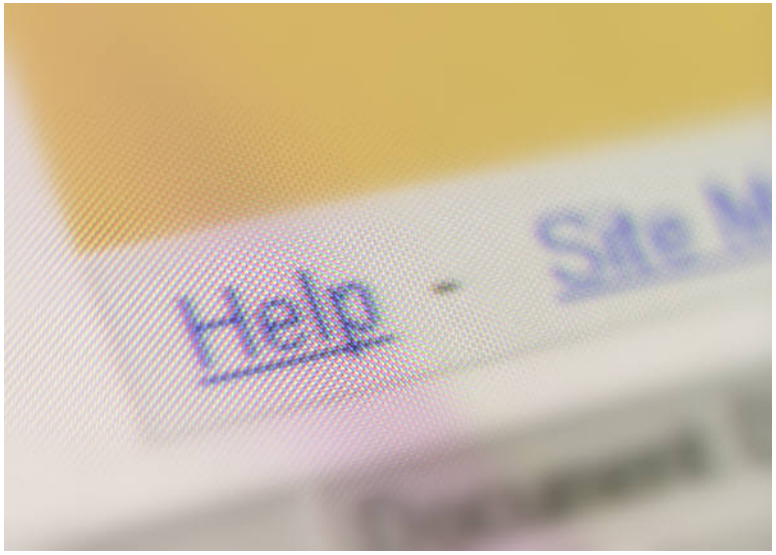
Buffy Bass-Douglas
Buffy_Bass_Douglas@bcbst.com
(423) 535-3856

Middle Grand Region

Nathan Key
Nathan_Key@bcbst.com
(615) 760-8707

West Grand Region

Sheldon House
Sheldon_House@bcbst.com
(901) 544-2170



Provider Service Line

1-888-747-8955

Provider Administration Manuals

www.vshptn.com or www.bcbst.com

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