



Home and Community Based Services Waivers

Presented By:

The Division of Medicaid and Health Financing,
Bureau of Authorization and Community Based
Services

February 2012

Factors Affecting Federal and State Long Term Care Policy



- HCBS Alternatives
- Olmstead Decision
- New Freedom Initiative
 - Nursing Home Transition Grants
 - System Change Grants
 - Re-Balancing Initiatives

- **Demonstration Project LTC-MC (FlexCare, WeberMACS and Molina Independence)**
 - Started 1999
 - Managed Care Design
 - De-Institutionalization
 - Choice of Long Term Care Services and Settings
 - Cost Neutrality
 - Limited Choice of Providers
 - Limited Areas Served

Eligibility

■ Medicaid stay

1. Is age 21 or older
2. Meets nursing facility level of care
3. Is Utah Medicaid eligible
4. Is currently residing in a Medicaid certified nursing facility for at least 90 days (ex. hospital and/or nursing facility)
5. Does not meet “Intensive Skilled” level of care
6. Does not meet ICF/ID level of care

Eligibility

■ Medicare stay

- Must meet all criteria stated in the previous slide except item #4, and
- Is currently on a Medicare stay and residing in a Medicare certified facility that is not an Institution for Mental Disease for at least 30 days and
- Will discharge to a Medicaid facility for sixty days, absent waiver services

- **Current Waiver Participants**
 - Currently receiving Medicaid reimbursed services from *another* Medicaid 1915(c) Waiver
 - Has been identified as in need of immediate or impending nursing facility care if not for the services of the New Choices Waiver

Application and Enrollment Process



- Applicant or person making the referral contacts with the Bureau of Authorization and Community Based Services (BACBS)
- BACBS screens applicant's eligibility to apply for the program and sends application packet

Application Packet



- Will include:
 - Welcome letter with checklist
 - Request for Evaluation
 - Freedom of Choice Consent Form
 - Nursing Facility vs HCBS
 - Choice of Case Management Agency
 - Authorization to Disclose Health Information

Application Packet, cont.



- Information on available case management agencies
- Fact sheets on other waivers
- Self-addressed stamped envelope

Application Process



- Applicant will complete the forms in the packet and return them to the BACBS in the envelope provided or fax them to New Choices Waiver at: 801-323-1586
- BACBS will review the information and determine initial eligibility

Application Process



- BACBS Representative will contact applicant
 - Discuss Services
 - Freedom of Choice will be discussed
 - Case Management Agency Selected

- BACBS will notify Case Management Agency of potential participant.

Case Management Assessment



- MDS- HC is the assessment tool used to determine needs
 - Completed by the Case Management Agency Registered Nurse or Physician
- Level of Care
 - Case Management Agency will complete and submit the initial Level of Care (LOC) Determination Form to the BACBS within 14 days of receiving the application

Level of Care

- BACBS will notify Resident Assessment if the CMA determines that applicant does not meet Nursing Facility Level of Care.
 - Resident Assessment will review LOC determination and provide technical assistance to Case Management Agency.
 - New LOC will be submitted if LOC standards are met.

Level of Care, cont.

- BACBS will be notified of the outcome by Case Management and Resident Assessment.
- Resident Assessment will follow up with participant if they agree that LOC is not met, and New Choices Waiver application will be closed.

Level of Care, cont.



- Level of Care Determination Forms must be filled out accurately
 - Information that you used in one section cannot be used to qualify in a subsequent section
 - Specifically, Level of Care Criterion 3 is related to the medical condition/diagnosis and is not related to the inability to perform ADLs or cognitive dysfunction. Criterion 3 addresses what is happening with the applicant/participant medically. An example would be Type II diabetes, renal failure, CHF, COPD, dialysis, etc.

Level of Care, cont.

Once a client has been admitted to the New Choices Waiver:

- Must continue to meet nursing facility level of care
- All participants leaving a hospital, nursing facility, rehabilitation stay or experiencing another substantial health status change, must be screened to determine if a full LOC reassessment is warranted
- Health Status Screening form must be completed and submitted to the BACBS within seven business days of discharge from any of facilities listed above
- Document results of screening in case file

Level of Care, cont.



- LOC reassessments must be performed by the RN in the 12th month from the initial assessment date
- An additional assessment may be necessary to coordinate assessment and care plan dates in the first year of service

Rental Agreements

- Case Managers will assist clients with determining housing options
 - Own home
 - Family home
 - Assisted Living
 - Independent Living
- A rental agreement must be submitted to the Bureau of Authorization and Community Based Services

Rental Agreements

- Must be accurate and complete
 - Complete address, including zip code
 - Beginning or effective date
 - Home or facility phone number
 - All signatures
 - Utilities broken out if possible
 - Allows deductions for “special income group”

Medicaid Eligibility Notification



- BACBS will complete 927 form based on Case Management LOC assessment and Rental Agreement.
 - Will send this to Long Term Care Eligibility for Home and Community Based Services financial eligibility determination.
- Eligibility will “work” the case and return financial eligibility determination to BACBS.
 - If applicant is not financially eligible, the Eligibility worker will send out notification of determination.
 - BACBS will notify Case Management Agency.

Care Plan Development



- Comprehensive Care Plan based on assessed needs and available resources
- Identify care plan type: Initial, Annual or Significant Change
- Identify all services the participant will receive, regardless of the funding source
- Assess number of units needed for the year – monitor and submit revised plan if need increases after three months

Care Plan Development, cont.



- Update as needed to address changing needs, e.g. after hospital stays
- Adding services or changing number of units does not give a new start or end date to the care plan
- Reviewed and updated annually (within 12th month) or as assessed needs change
- Coordinate with the MDS-HC assessments:
 - Initial care plans must be completed within 60 days of the initial MDS-HC assessment.
 - Annual care plans must be completed with 14 days of the annual MDS-HC reassessment.

Determining Service Units

- Refer to HCPC coding and Rate Sheet
- Residential Service: one unit = one day
- Specialized Medical Equipment and Supply items: use smallest unit and frequency, e.g., two units daily, and identify the item
- Attendant Care: use Unit Allocation Form to determine number of units
- Chore Services – No one else responsible
- Homemaker – Temporary absence or ability

- Case management unit requests of 16 units or more per month must be accompanied by a summary of why the additional units are needed
- This summary must be updated yearly as well as whenever there is a request for additional units
- Make sure all required signatures are on the care plan

HCPCs

- Correct HCPCs must be listed on the Care Plan and on the Service Authorization form.
- Play close attention to services that may have more than one code or codes that may cover more than one service.

HCPCs

Adult Residential Living

- T2031 – Level I and Level II
- T2016 – Alzheimer secured/locked unit

Non-Medical Transportation

- T2004 – Public Transit Pass
- T2003 – One Way Trip
- S0215 – Per Mile

HCPCs continued...

Specialized Medical

- T2029 – Specialized Medical Equipment/Supply/nutritional supplement
- T2029 - Specialized Medical Equipment/Supply/raised toilet seat
- T2029-Specialized Medical Equipment/Supply/bed cane

HCPCs, continued

- All specialized medical equipment requests must have physicians' orders
- Estimated cost of product must be submitted for anything other than the nutritional supplement
- Physician's orders must be updated annually

Freedom of Choice

- Educate participants about their right to choice of providers and services
- Assist participants to select service providers from the list of available providers developed by the BACBS
- Support participant's choice
- Assist with requesting a fair hearing if choice of services or provider is denied

Care Plan Submission



- BACBS must approve all Care Plans prior to implementation
- When approved, the participant can begin receiving services described in the care plan

Service Authorization



- Authorizes type, amount and frequency of services identified on the care plan
- Must be received by provider prior to any service being rendered
- Must be updated and resent to provider any time a change in service is indicated
- Note any services that exceed authorization
- Updated yearly or whenever services/units are adjusted on a care plan

- **Why do we have service authorizations?**
 - Provides billing information to service provider, including HCPCs and Medicaid ID number
 - Establishes exact duration, amounts and types of services authorized
 - Liability for services provided
 - Recoupment potential
 - Providers have been asked not to accept any clients without first obtaining a service authorization form
 - Must be updated annually and at significant change

Types of Service Authorization



- **Service Authorization Form**
 - ✓ This covers non residential service providers
 - ✓ Please make sure that it is filled out correctly and completely
- **Adult Residential Service Provider Authorization Form**
 - ✓ This form is for Assisted and Independent Living Facilities

Types of Service Authorization, cont.



- Case Management Agency/Financial Management Service Agency Authorization for Self-Administered Services
 - ✓ Identifies authorized services to the FMS Agency
 - ✓ Always double check HCPCs on all Service Authorizations for accuracy

Self-Administered Services



- If assessed to need services that are available under the Self-Administered Services Method
 - Attendant Care – \$2.66 per quarter hour
 - Chore Services – \$3.48 per quarter hour
 - Homemaking Services - \$14.50 per hour
 - Hourly Respite - \$18.99 per hour
 - Daily Respite (6 or more hours) - \$51.80

Self-Administered Services, cont.



- And is interested in administering their own services, use three part packet:
 1. Case Manager Packet
 2. Participant Packet
 3. Employee Packet

Self-Administered Services Case Manager Packet



- Case Manager Checklist
- Case Management Responsibilities
- Unit Allocation For Attendant Care
- Service Authorization Form

Self Administered Services Case Manager Packet, cont.



– Review With Participant:

- Letter of Agreement
- Participant Eligibility and Responsibilities
- Participant or Designee Option
- Financial Management Services Role and Choice

Self-Administered Services Employer Packet



- Employer Checklist
- Letter of Agreement
- Back-up Service Plan
- Utah Criminal History/Bureau of Criminal Identification Form
- Employment Agreement Form
- New Choices Waiver Provider Code of Conduct
- Incident Reporting Protocol and Form

Self-Administered Services Employer Packet-Notebook



Provide Participant Notebook with tabs for:

- Letter of Agreement
- Current Care Plan
- Back-up Plan
- Utah Criminal History/Bureau of Criminal Identification Form
- Employment Agreement
- Employment Forms
- Training Plan
- Provider Code of Conduct
- Incident Reporting Protocol
- Selected FMS Provider Packet

Self-Administered Services Employee Packet



- Employee Checklist
- Utah Criminal History Record Review
- Employment Agreement
- Provider Code of Conduct
- Financial Management Services Forms

Self Administered Services Utah Criminal History/Bureau of Criminal Identification Form



- Utah Criminal History/ Bureau of Criminal Identification Form: No payment will be authorized for any prospective employee until this form is completed and signed
 - Form must be completed by every participant/participant designee (Employer)
 - Copies kept by CMA and Employer

Self Administered Services: Monitoring



- Monitor quality and effectiveness of service
- Relationship between Employer and Employee
- Ongoing contact with Employer and Employee

Self Administered Services: Monitoring Continued



- Initial face to face visit with participant and employee is required within two weeks of start up of service
- Monthly contact
- Event based contact
- Review and update the Back-up Plan routinely to make sure it remains current

Self-Administered Services Notify FMS When:



- Participant is no longer eligible for services
- New or discontinued Service Authorization
- Change in service units or frequency
- The participant is deceased
- Change in Case Managers
- Participant is in a hospital or nursing home
- The participant has moved

Self-Administered Services Discontinuation



- Participant is unable to direct services and has no designee to direct services
- Participant is deceased
- Participant or designee fails to provide required documentation or refused to follow agreed upon services as ordered in the Care Plan

Self-Administered Services Discontinuation, cont.



- Evidence that service is not being performed
- Evidence of abuse, neglect or exploitation by employee or designee
- Participant does not maintain Medicaid eligibility or does not cooperate with authorization changes or rules

Self-Administered Services

Review of Case Manager Checklist



Provide information packets, including:

- Case management forms
- FMS provider packet
- Employer notebook
- Submit Care Plan
- Send Service Authorization and all required documents to FMS provider
- Receive notice from FMS when documents are complete and begin services

Case Management: Monitoring



- Meet with the participant as assessed necessary to monitor the quality and effectiveness of service and the participant's health and safety
- Ensure that services are being provided as ordered in the Care Plan – Units, Frequency, Duration
- Initiate appropriate reviews of needs and care plan as indicated

Case Management: Monitoring



- Minimum of monthly contact, either face to face or by telephone
- Event based face to face or telephone contact, as needed
- Minimum of one face to face visit per quarter and one reassessment per year
- For SAS participants, meet face to face with participant and employee within two weeks of start up or service

Case Management: Monitoring



- If you see any health or safety issues in the environment during visits, e.g. missing smoke detector, report it and make a note of issue and resolution
- Communicate with assisted living and nursing facilities regarding changes, moves and incidents
- For SAS participants, review and update the Back-up Plan routinely to make sure it remains current

Case Management: Monitoring

- You should be notified any time a participant does not sleep in the assisted living facility for any reason, including:
 - Hospitalization
 - Rehabilitation
 - Overnight visits with family or friends
 - Vacation
- You should also be notified when the participant returns

Case Management: Activity Guidelines



- Few activities require both RN and social worker
- RNs are primarily responsible for MDS-HC assessments, reassessments and LOC determinations (once a year)
- Social workers assist participants with accessing and coordinating services
- Simply talking is not billable

Case Management: Activity Guidelines



- Example:
 - Client needs to visit the doctor for a checkup and needs transportation - Social Worker can coordinate this
 - Client is seeing the doctor for an issue requiring extensive/close medical follow up - The RN may be involved rather than the Social Worker

Case Management: Activity Guidelines



- RN:
 - MDS-HC assessments, reassessments and LOC determinations
 - Serious medical issues or incidents requiring professional medical follow up that is not otherwise provided
 - Sign care plan

Case Management: Activity Guidelines



- **Social Workers:**
 - Complete care plan and update in accordance with assessed needs
 - Coordinate services across Medicaid programs
 - Assist client in accessing available Medicaid State Plan services, including incontinence supplies
 - Assist client with service/provider selection
 - Ensure that client is aware of their right to change living environments

Case Management: Activity Guidelines



- Assist with service coordination regardless of funding source, including community services and activities
- Assist with fair hearing requests as necessary
- Receive, review and respond as indicated to incident reports that do not require professional medical follow up

Incident Reporting Protocol



- Providers must notify the Case Management Agency within 24 hours of the following incidents:
 - Any injury requiring attention from a medical professional and/or hospitalization
 - A pattern of falls resulting in injury
 - Involvement in a fight or physical confrontation
 - Any medication or treatment error resulting in marked adverse side effects

Incident Reporting Protocol



- Providers must notify the Case Management Agency within 24 hours of the following incidents:
 - Any injury requiring attention from a medical professional and/or hospitalization
 - A pattern of falls resulting in injury
 - Involvement in a fight or physical confrontation
 - Any medication or treatment error resulting in marked adverse side effects

Incident Reporting, cont.

- Involvement in illicit drug use, intentional misuse of prescription medications, or chronic intoxication
- Involvement in any other situation or circumstance that affects the participant's health, safety or well being
- Suspected abuse, neglect or exploitation
- Any human rights violations such as unauthorized use of physical or chemical restraint
- Any injury or medication error resulting in hospitalization

Incident Reporting, cont.



- Suspected Medicaid Fraud
- Any aspiration or choking incident that results in the administration of the Heimlich Maneuver, emergency medical intervention, and/or hospitalization

Incident Reporting, cont.

- Non-Residential Service Providers and Self Administered Service Employees also must notify the Waiver Case Management Agency by telephone, fax, or email of any incident on the aforementioned list.

Incidents that are Critical

- The following incidents require immediate notification to the BABCS, as well as the Waiver Case Management Agency by telephone, fax or email:
 - Unexpected or accidental death of a waiver participant
 - Suicide attempt
 - It has been determined that a waiver participant is missing under suspicious or unexplained circumstances
 - Any incident which is anticipated to receive media or legislative attention or public scrutiny
- Verbal notification is permissible, but written notification must follow within 24 hours of verbal notification (residential providers)

Incident Reporting, cont.



- All providers, including Residential, Non Residential and Self Administered Service Employees must report any actual or suspected incidents of abuse, neglect or exploitation of a waiver participant/vulnerable adult to Adult Protective Services or local law enforcement. (UCA 62-A-3-301)

Incident Reporting, cont.

- Case Management Agency is responsible for:
 - Receiving incident reports & immediately forwarding them to BACBS
 - Reviewing reports
 - Responding when indicated
 - Maintaining a record of all incident reports in the participant's case file
 - Addressing any identified needs
 - Facilitating a resolution of any causal factors
 - Providing follow up and support

Incident Reporting, cont.



- Verifying that reports of abuse, neglect or exploitation have been reported to Adult Protective Services or local law enforcement

Incident Reporting, cont.



Submit notification to BACBS:

FAX: 801-323-1586

Email: NewChoicesWaiver@utah.gov

Telephone:

Vicki Ruesch : 801-538-6148

Blake Minardi: 801-538-6497

Trecia Carpenter: 801-538-6861

Incident Reporting, cont.



- Case Management Agency must maintain an incident log of all negative incidents reported to them, including verbal reports by non residential service providers.

Incident Reporting, cont.



The Incident Log must include:

- Date incident was reported
- Participant's name
- Date of incident
- Nature of incident
- Brief description of Case Management Agency response
- Outcome of incident

Disenrollment

- Three types of disenrollment
 - Voluntary
 - Pre Approved Involuntary
 - Special Circumstance Involuntary

Disenrollment, cont.



- **Voluntary:**
 - Client chooses to disenroll from the waiver program
 - This program is voluntary and participants can choose to disenroll at any time

Disenrollment, cont.

- Pre Approved Involuntary:
 - Client death
 - Client moves to nursing home, hospital or rehab – disenroll after 30 days
 - Client no longer meets financial requirement for Medicaid program eligibility – may return to program when financially eligible
 - Client has moved out of state
 - Client has not paid spenddown
 - Client whereabouts are unknown

Disenrollment, cont.

- Voluntary and Preapproved Involuntary
Timeframes:
 - Participants admitted to nursing homes, hospitals or rehabilitation units must be disenrolled after 30 days
 - If it is clear at the time of admission that the individual will be there for 30 days or more, disenroll

Disenrollment, cont.



- Special Circumstances Involuntary:
 - CMAs send notice of intent to disenroll, including supportive documentation to BACBS
 - Interventions
 - Discharge Plan
 - Notice of Agency Action
 - Right to Appeal
- CMAs cannot disenroll participants from the waiver. Only BACBS has authority.

Disenrollment, cont

- Special Circumstances Involuntary Timeframes
 - If a special circumstance involuntary disenrollment has been approved by BACBS, a participant has the right to appeal the decision.
 - If appealed within 10 days, the participant can choose to continue services during the appeal process.

Documentation

Document each contact or event



- Case activities, including:
 - Required assessments, updates and documents
 - Case contacts, events, progress, etc.
 - Documentation should support case management units ordered on the Care Plan

Documentation Should be -



- Factual: Document behaviors, actions, and statements
- Clear: Descriptive, in the order of occurrence and easily understood
- Concise: Write enough to adequately describe the activity including only that information that is necessary and relevant

Documentation Problem Resolution:



- Describe the issue or concern
- Evaluate possible solutions and select the one you will use
- Implement the solution
- Evaluate the effectiveness of the solution

Documentation Correcting Errors



- Draw a single line through the error
- Write the correction next to the error
- Initial the error and write the date of correction
- Do not use white out or scribble over the error

HCPC Coding and Rates for New Choices Waiver Services



- Please see Rate Table or Website:

<http://health.utah.gov/ltc/NC/Home.htm>

NCW Quality Assurance



- Assurances that must be met with all 1915(c) waiver programs:
 1. Health and welfare
 2. Financial accountability
 3. Provider qualifications
 4. Care planning
 5. Administrative authority
 6. Level of care

- For each assurance, Utah has established methods to measure how well the waiver program is performing
- The NCW Operating Agency (BACBS) is responsible to measure waiver performance on a continuous and ongoing basis

- BACBS will audit the records of each case management agency on an annual basis including:
 - Log notes, care plans, back-up plans, assessments, waiver forms, service authorizations, paid claims, incident reports/logs, personnel files/licenses, provider licenses, Medicaid agreement, etc.

NCW Quality Assurance, cont.



- When deficiencies are identified, remediation strategies will be applied
 - Corrective action plans
 - Recovery of funds when applicable

- Maintain current case files with all required forms, assessments and logs
- Document activities well
- Know the performance measures
- Maintain current personnel files and provider licenses
- Submit documentation when requested

Billing Methods



- Paper Claim
 - CMS 1500
 - Preprinted form
 - There are different vendors that have software to complete these forms
 - NOTE: All Medicaid paper claims must be sent via the U.S. Postal Service.
- Electronic Claim
 - Electronic format of the CMS 1500
 - All claims pass through UHIN

Billing and Payment Information



- Providers can only bill for services they have already provided
- Providers can only bill for services that they have been authorized to provide
- Providers must use the correct HCPCS Coding
- Providers must enter the correct waiver code into the procedure code modifier box – U8

Timely Filing of Medicaid Claims



- ❑ All claims and adjustments for services must be received by Medicaid within twelve months from the date of service. New claims received past the one year filing deadline will be denied.
- ❑ Any corrections to a claim must also be received and/or adjusted within the same 12 month timeframe. If a correction is received after the deadline, no additional funds will be reimbursed.
- ❑ The one year timely filing period is determined from the date of service or “from” date on the claim.

Billing Timelines



- Providers determine how often they bill
- All claims and adjustments for services must be received by Medicaid within twelve months from the date of service
- Claims are processed weekly
- Paper claims must be received by Tuesday to be processed that week
- Electronic claims must be received by Thursday at 5:00 PM to be processed that week

Denied Claims

- Problems and/or errors will need to be resolved with DOH Medicaid Operations
- If a claim has been denied for incorrect information, correct the claim and resubmit it, rather than calling Medicaid Operations
- Until the claim is billed correctly, it cannot be processed

Payments



- Providers will receive payment directly from Medicaid
- Weekly EFT
- Occurs on the second business day of the week
- Normally Tuesday except for weeks with Monday holidays

Additional Billing Information



- Services and Supplies the New Choices Waiver will not pay for:
 - Supplies or services that the Medicaid State Plan or any other source pays for, e.g. incontinence supplies
 - Services that are included on Attachment B Adult Residential Services, e.g. laundry

Adult Residential Services Billing



- Only days and nights spent in the facility can be billed
- Hospital or nursing home stays, overnight visits or vacations cannot be billed
- If a client moves from one facility to another the facility the client is moving FROM bills for moving day

Utah Health Information Network



- Contact UHIN to set up account and get your trading number.
 - <http://www.uhin.com/>
 - **Phone:** (801) 466-7705
 - **Fax:** (801) 466-7169

Medicaid Contact Information



**Medicaid Customer Service staff are available to take your calls:
Monday through Friday 8:00 a.m. - noon and 1:00 p.m. - 5:00 p.m.**

- In the Salt Lake City area, call 801-538-6155.**
- In Utah, Idaho, Wyoming, Colorado, New Mexico, Arizona, and Nevada, call toll-free 1-800-662-9651.**
- From other states, call 1-801-538-6155.**
- FAX Line: (1-801) 538-6805**
- Or write to:**
 - Department of Health**
 - Division of Medicaid and Health Financing**
 - P.O. Box 143106**
 - Salt Lake City UT 84114-3106**

NOTE: All Medicaid paper claims must be sent via the U.S. Postal Service.

Provider Manual



- Please see handout or Website:

<http://health.utah.gov/ltc/NC/NCHome.htm>

New Choices Waiver Contacts



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(801) 538-6497
- Trecia Carpenter
(801) 538-6861
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