BlueCare Tennessee

CHOICES NEWSLETTER

BlueCare Tennessee CHOICES Program

AUGUST 2015

New Rule for Home and Community Based Services Settings

The Centers for Medicare & Medicaid Services (CMS) vision for long-term care is for the system to be organized around the needs of the individual rather than around the settings where care is delivered.

In all Home and Community-Based Services (HCBS) settings, the state must ensure participants have:

- Integration in the community
- Choice among settings
- Choice of services and supports and who provides them
- Freedom to furnish or decorate their sleeping or living unit
- Control over their schedule
- Access to food at any time
- Visitors of their choice at any time
- Rights to privacy, dignity, respect and freedom from coercion and restraint
- Protections from eviction and an appeals process comparable to those provided under landlord tenant law
- Independence in making life choices regarding daily activities, physical environment and with whom to interact
- Privacy in their sleeping or living unit, including the ability to lock their door and choose their roommate

All provider self-assessments must be complete and validated by the MCO, including the transition plan if necessary, by Sept. 30, 2015. **All action steps of the transition plan do not have to be complete by Sept. 30, 2015,** but all action steps and their timeframes must be part of the plan by this date. The MCO will monitor the plan to ensure compliance to the HCBS settings rule is met. If you need help to achieve compliance, please contact the MCO.

Reminders

1. Providers must provide evidence that policies and procedures are in place and regularly assessed for effectiveness AND made available to individuals served.
2. Provider Transition Plans must have action steps and timelines to come into compliance.
3. Providers must make any necessary revisions or obtain the documents required to come into compliance.
4. Evidence of Compliance and Transition Plans will be rejected if they do not address the communication and implementation of the new or revised policy to their staff and the people they serve.
5. Providers unwilling or unable to comply must help with transition assistance to ensure all individuals transition to an appropriate provider type, maintaining continuity of services.

To help ensure ongoing compliance and adherence to the rules, on-site visits will incorporate annual reviews of the HCBS required components.

Requesting Assistance? Include Details

When you need assistance, we want to provide it as quickly as we can. The details you provide in your requests will help us give you more efficient service. Here a few items to include in each of your requests:

- Provider Number
- Member Name
- Member Identification
- Date of Service
- Type of Service
- Description of the Issue
- Contact Person

Provider Plan of Care Attestation Process

Person-centered planning helps our members have choice and control over their lives, and the services and support they receive. **The person-centered planning process must allow** the person to lead the process and include family members, friends, and others selected by the individual when possible. It must also give people the information they need to make informed decisions about their choice of services and providers based on the person's strengths, preferences, goals and desired outcomes.

BlueCare Tennessee® partners with Sandata Technologies to accept electronic signatures as part of the Plan of Care notification and acceptance process. This impacts all providers who use the Electronic Visit Verification (EVV) system. You will receive complete plans of care that outline the person-centered plans of our CHOICES members. Providers are required to confirm receipt of the plan by attesting in EVV upon assigning workers. If you do not use EVV for CHOICES services, BlueCare Tennessee will obtain a verbal acknowledgement from you to document the system of record. Please ensure you are attesting to avoid delay in reimbursement.

One-Time Schedule Change Reminders

- Providers should not request one-time schedule changes.
- Only the member should request this type of schedule change.
  - To make the change, the member should call 1-888-747-8955 and press Option 1.
- If the request is approved, a support team staff member will revise the authorizations and notify all parties via email and/or phone that the one-time schedule change has been approved or denied.
- When providers are aware of a schedule change we want to ensure members have continuity of services.
- For urgent requests, please call 1-800-468-9736.
- For questions regarding our process, please contact your provider network manager.

Mobile Verification Visit Program for Home and Community-Based Services

CHOICES HCBS is in the process of implementing the BlueCareConnect℠ Mobile Verification Visit (MVV) program for home services.

To meet our target completion date of Oct. 1, 2015, BlueCare Tennessee will schedule member device shipments during regularly scheduled care coordinator member visits. The care coordinators will activate the devices and train members on the Health Harmony application, which notifies them when a caregiver is late or will miss the visit.

The BlueCareConnect MVV app will record check-in/check-out times, as well as tasks that were performed during the visit. This data will be available in Sandata's Santrax Agency Management (SAM), where the Electronic Visit Verification (EVV)/Telephony call information is currently displayed. In addition, a unique indicator will display for visits performed through the MVV application, which will provide your agency with the ability to identify such visits.

With our BlueCareConnect application, your caregivers will have the ability to:

- View their member schedules for each day.
- Verify scheduled member visits and record tasks.
- Set up and verify unscheduled visits.
- Receive visit cancellation alerts and notifications.

Mobile Device Training

BlueCare Tennessee Provider Relations will conduct device training sessions for our home services agencies as well as for those who want a refresher course. **Training dates for 2015: Aug. 28; Sept. 11; Oct. 9 & 23; Nov. 6 & 20; Dec. 4 & 18.**

Please contact your provider network manager about your training needs.

Questions?

Do you have additional questions? Please contact your assigned regional provider network manager.

Provider Resource: Provider Administration Manual

The BlueCare Tennessee Provider Administration Manual contains comprehensive information regarding BlueCare and TennCare*Select* operating policies and procedures. It also has information about the TennCare CHOICES Long-Term Services and Supports (LTSS) program. LTSS is a Medicaid system redesign initiative that integrates long-term services and supports, including nursing facility services and HCBS alternatives to nursing facility care, into the existing TennCare managed care delivery system.

For easy access, make this link one of your favorites. bluecare.bcbst.com/forms/Provider%20Information/BCT_PAM.pdf

Community Living Support

Community Living Supports (CLS) is a community-based residential alternative service for seniors and adults with disabilities that includes options for community residential independence through community integration. CLS helps ensure residents' choices and rights and must adhere to the new HCBS setting rule.

We are seeking qualified providers who want to contract with BlueCare Tennessee CHOICES. Provider eligibility for the program includes the following guidelines:

- The CLS1 provider is licensed and contracted by the Department of Intellectual and Developmental Disabilities (DIDD) as a Mental Retardation Semi-Independent Living Services Facility in accordance with licensure regulations.

- The CLS2 provider is licensed and contracted by the DIDD as a Mental Retardation Semi-Independent Living Services Facility in accordance with licensure regulations.

- CLS3 provider is licensed and contracted as a Mental Retardation Supported Living or Residential Habilitation Facilities provider by the DIDD in accordance with licensure requirements.

To learn more about or to begin the contracting process, please email your group's information to: CHOICESProviderRelations@bcbst.com.

A CHOICES provider network manager will contact you to help guide you through the process, which includes providing your organization's financial solvency by completing the Financial Z-Score Tool.

CHOICES Provider Spotlight: Home with Hope

CHOICES Minor Home Modification providers are an integral part of our program. By providing and installing home mobility aids, such as wheelchair ramps and hand rails to showers, our members have increased mobility and accessibility in their homes. This supports their integration in the community and supports their person-centered plans.

Home with Hope is passionate about serving CHOICES members and it's evident in their quality of work. We acknowledge Home with Hope as one of our excellent service providers.

As a statewide provider, Home with Hope puts members first, ensuring that deadlines are met with cost-effective and timely service on every request. We salute Matt Ockerman, Don Smith and Monica Osteen for always going above and beyond to meet the needs of members. We appreciate their professionalism and work with BlueCare Tennessee to meet contractual requirements for each home project. Keep up the great work.

Re-Credentialing

CHOICES has a new provider enrollment form that needs to be completed for initial and ongoing credentialing. Click this link to complete the **CHOICES Enrollment Form**. The form is needed for all initial and annual site visits.

CHOICES Critical Incident Reporting

The Bureau of TennCare updated the Contractor Risk Agreement regarding CHOICES critical incidents July 1, 2015. **This update did not affect reporting timelines.** Details of the changes are listed below.

- Your organization is required to have a process in place to provide and document initial and ongoing education to your employees who provide services to CHOICES members, including critical incident reporting; and

- Your policies and procedures must be adequate and inclusive of all details surrounding this process. During your site visits, the provider network manager will review each policy and procedure to determine if the details documented support the contractual agreement noted in C.R.A 2.11.3.

Effective July 1, 2015, the definition of a critical incident:

- Occurred in a home and community-based long-term care service delivery setting, including: community-based residential alternatives, adult day care centers, other CHOICES HCBS provider sites, or a member's home or any other community-based setting, if the incident occurs during the provision of covered CHOICES HCBS;
- Occurred during the covered provision of HCBS regardless of whether the provider is believed to be responsible for the incident;
- Incident involved an HCBS worker;
- Incident is one of the following CI types:
  - Known or suspected sexual abuse
  - Known or suspected physical or mental abuse
  - Known or suspected neglect
  - Theft (medication or property)
  - Financial exploitation
  - Medication error
  - Severe injury
  - Unexpected death - Any unexpected death of a CHOICES member, regardless of whether the death occurs during the provision of HCBS.

Following the initial reports (24-hour verbal report, 48-hour written report, 24-hour Adult Protective Services (APS) report if applicable), a full follow-up investigation MUST be completed by agency and submitted to BlueCare Tennessee via email or fax within 20 days of discovery. Please note that this follow-up report should include the following:

- Interview results conducted with member and worker
- Worker written statement – if unable to provide worker written statement, please note reason it cannot be obtained
- Background check info and OIG/LEIE info for each worker involved
- Information regarding any other complaints/incidents involving worker or workers
- Training information prior to incident and after incident for each worker involved – must provide date and topics for training prior to and after incident
- Actions to prevent reoccurrence and contributing factors
- Status of member's services at the close of the investigation
- Narrative providing information as to what actions were taken to complete investigation, findings of investigation, actions taken involving worker and APS or police investigation (if applicable)
- Any credible evidence found (if there is credible evidence to support, please provide the evidence; if there is evidence to dispute, please provide the evidence)
- Conclusion based on findings of the investigation
- Worker employment status (if worker is no longer employed due to quitting or termination, please provide the date the worker was terminated or quit)

Please provide any additional documents related to incident if applicable (ex: police report). Please note that your agency does not need to provide actual drug screen documents, only the result of the screen.

UPDATE: Enhanced Respiratory Care – Quality Monitoring

BlueCare Tennessee partners with Eventa to support monitoring of the quality of Enhanced Respiratory Care (ERC) services provided by nursing facilities. Monitoring will include monthly reviews conducted by the respiratory care practitioner from Eventa. The onsite quality reviews, which began in July, audit each member receiving ERC. The review and oversight of these cases will help ensure the best care for members at lower costs.

With these onsite reviews in place, nursing facilities will no longer need to submit 30 days of medical documentation to the MCO. However, nursing facilities will continue requesting chronic ventilator, frequent tracheal suctioning and ventilator weaning through the standard process.

Additionally, clinical reviews will be submitted to the Bureau of TennCare as applicable, along with any recommendations for the optimal care for members. The Provider Relations team will contact you about an additional upcoming training session with Eventa and BlueCare Tennessee.

The ICD-10 Change – How it Impacts CHOICES Providers

International Classification of Diseases, Tenth Revision (ICD-10), is published by the World Health Organization (WHO). For our purposes, it provides uniform language to describe diagnosis and procedure information for claims processing, research and analysis. The current system used in the United States is ICD-9-CM (Clinical Modification).

On July 31, 2014, the Department of Health and Human Services announced the ICD-10 effective date as Oct. 1, 2015. This ruling applies to all entities covered under the Health Insurance Portability and Accountability Act (HIPAA).

Here is how this change impacts the submission and process of your claims:

- If the date of service is prior to Oct. 1, 2015, the claim should be submitted with the ICD-9 diagnosis code.
- If the date of service is on or after Oct. 1, 2015, the ICD-10 diagnosis must be filed.
- If the diagnosis format is not appropriate, based on the date of service filed, the claim will be rejected or returned to the provider. Claims will not be processed and denied.

Note: EVV Providers, the ICD-10 code changes will be handled systemically without provider intervention required. Electronic and online claims submissions will require the provider to enter the correct diagnosis code. Additional details regarding this process will be provided by the Provider Relations Department.

Provider Network Managers			
Manager	**Region**	**Phone**	**Email**
Bianca Merrell	East Tenn. – South Region	(423) 535-5900	bianca_merrell@bcbst.com
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Jeff West	Middle Tenn. – South Region	(615) 565-1937	jeffrey_west@bcbst.com
Vinny Cardi	Middle Tenn. – North Region	(615) 565-1907	vincent_cardi@bcbst.com
Ashley McDonald	West Tenn. – East Half/Shelby County M-Z	(901) 544-2136	ashley_mcdonald@bcbst.com
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