Monthly Provider Call

Updated thru January 2017 Provider Call

EVV – July 7, 2016

1. What is the minimum number of hours a client can work to be qualified under Supports Waiver Supported Employment?

   Answer: There is no minimum number of hours at this time that the individual has to work to qualify for SE services. However, SE services are only billed when the job coach is following up or assisting the individual with work related activities. The total of Supports Waiver SE individual, SW prevoc and SW day hab combined cannot exceed 5 hours a day. SW Group employment is a per diem and cannot be billed on the same day as other SW SE/Prevoc/Day Hab services.

2. Will the EVV training site be available for training before Supported Employment becomes effective Sept. 1, 2016? If not, why?

   Answer: Providers of Supported Employment already have access to the production LaSRS system. If additional training is needed for Supported Employment services, then please contact SRI prior to September 1 to set up a refresher training on the actual clock in/out process within LaSRS.

3. Once you clock out the client from morning transportation and services check in starts, do you sign them in on payroll at time service start? Example: arrive at worksite, clock out morning transportation at 07:49am. Work starts at 8:00am or should work start at 07:49am when you arrive getting off the van going into the building preparing to start work?

   Answer: The time for which you clock a participant into a service once they have arrived at the center is up to the provider agency. You should clock them in when the services are ready to be delivered. The time you put on an individual's timesheet for payment is up to the provider agency. It is recognized that all supported employment time may not match actual hours worked.

EVV/LAST – August 4, 2016

1. Explain the Supports Waiver "Information Only" cap of services message on blocked services report.

   Answer: The five hour cap for Supports Waiver is being enforced and deductions are being reported on the blocked service report. They are being reported as informational only and are there for the provider to reference since deductions are being applied to the services.

2. Will there be changes regarding EVV and SRI system (LAST and LaSRS)?

   Answer: SRI is continually updating the system based on comments and suggestions from providers. If you have any suggestions or comments, please feel free to contact us @ LAST@statres.com or LaSRS@statres.com.

3. Is there a plan to upgrade LAST to a web based application?
   Answer: There is no plan to upgrade LAST to a web based application at this time.

4. What is the progress on the MITC and LAST interface?

Answer: SRI is waiting on complete test data from MITC to move forward.

CMS Settings – July 7, 2016

1. For consumers who receive ACS services with one provider, but day hab or supported employment with another provider, is OCDD or Support Coordination encouraging those consumers to switch ACS providers so that all services are delivered by one provider?

   Answer: No we are not encouraging anyone to change providers. It is our intent to work with each provider to assist with coming into compliance with the rule. There has not been nor is there currently any issues with a person wanting to access multiple providers.

2. Are providers being encouraged to offer supported employment so that they do not lose their consumers? Employment is a big part with the Settings Rule.

   Answer: As an employment first state, we have been encouraging providers to work with people evaluating where they are at, what they would like to be doing and where it makes sense to assist people with locating employment even prior to the Settings Rule. We are asking that provides continue doing this.

3. Person-Centered Planning/Living Conditions/Rights: consumers who are competent majors with family involvement; if the family does not allow the consumer to participate in planning meetings or "over rule" a consumers wishes, which are not a health and safety concern, how do they want providers to handle these situations to ensure compliance with the Settings Rule?

   Answer: In these types of situations, we are going to have to work together to come up with strategies for how we handle this. Some initial thoughts in terms of strategies would include partnering together to assure that we provide education to individuals, families, and other identified entities; we need to look at training opportunities with SC agencies related to pc thinking/planning to assist them with better facilitating and maneuvering these types of situations.

CMS Settings – September 1, 2016

1. When will the licensing standards and program manuals be updated to reflect the changes occurring as a result of the CMS Settings Rule?

   Answer: We are in process of updating our transition plan for stakeholder input. As part of those updates we are including timelines to address the above noted areas. Manuals typically do not take a great deal of time for us to update. On average anything that has to be changed in rule can take us up to 9 months.

2. Guidance on Day Hab/ERT/SE Providers Transitioning or Changing Services to Comply with CMS Settings Rule: It would be helpful if guidance was afforded to help providers, implement smooth transitions in making significant changes to frequency, duration, intensity, and scope of participant's services. This includes giving adequate timelines for participant participation and compliance, adequate notice to participants/families of impending changes, ensuring compliance with person

centered planning during the process, and working with the SCA to ensure participants know all of their options.

Answer: Per the rule implemented by CMS, person centered planning was not an area to be included in the transition plan as the expectation is that it is already in place. There is a workgroup established that is in process of reviewing areas surrounding person centered planning. We are hoping to provide training/technical assistance in this area in the coming months.

In terms of frequency, duration, intensity and scope of service CMS does not identify specific amount of a particular service that must be provided to meet the expectations of the rule. CMS has indicated that how much someone goes out in the community or participates in a particular activity should be driven by the person and included in the person centered plan. We agree that through the person centered planning process, the team should be meeting to discuss all options and adequate notice and timelines should be allowed for when making changes.

CMS Settings – January 5, 2017

1. Will letter go out to families regarding the settings rules? Want to know if changes would be explained to families, what the changes are, and when changes will take place.

   Answer: Yes, OCDD has drafted a proposed letter to be shared with families related to the HCBS rule. The letter will be circulated within OCDD for a final review in January 2017. We will be asking Support Coordination to hand deliver these letters and explain the content of the letters to families during their scheduled visits in 2017. OCDD is open to suggestions from stakeholders related to other opportunities to educate families regarding the CMS rule.

RN Delegation – July 7, 2016

1. Providers are being asked to have current RN Dels and verification of staff training in the home (reference CMIS service log). Do not have a problem providing them upon request, but keeping up to date RN Dels in home is very difficult. Licensing requires that they be kept in the provider's permanent file.

   Answer: Providers are not required to keep RN Dels and verification of staff training in the home; however, these documents are required to be retained at the agency's office. The provider is required to make these documents available upon request by any appropriate office (Support Coordination, LGE, OCDD State Office, Health Standards, etc.). Providers are expected to keep in the home a listing of current medications and dosages. This can be through a MAR that is updated with each medication change, or a medical report completed at a doctor's visit, etc. The intent is that it is easy to ascertain the current medication regimen for the participant.

Hospital Admissions – 508 Denials – August 4, 2016

1. What is the process for a provider to get reimbursed for hours provided on days a participant is admitted to or discharged from the hospital?

   Answer: Forward the information below to the address listed. This type of denial requires a paper claim for reimbursement.
   - Remittance advice (RA) with 508 denial (only the page of the RA with the denial)

- Hospital admission and discharge paperwork with **time of admit and discharge clearly noted**. The hospital should be able to provide that document to the family/participant so you can submit it with billing.
- Timesheets for date of admit/discharge
- Service logs for date of admit/discharge
- CMS 1500 claim form for services provided on date of admit and discharge.
  - Copies of CMS 1500 forms (version 02-12) may be used as long as it is legible
  - Signature on form is no longer required
  - You must write "WAIVER" across the top of the claim form (see instructions for completing a manual claim on Louisiana Medicaid website at):

http://www.lamedicaid.com/provweb1/billing_information/CMS_1500_Waiver.pdf

Mail claim forms to:
Louisiana Department of Health, OCDD
Attn: Kim Kennedy
P. O. Box 3117, Bin 21
Baton Rouge, LA 70821-3117

Checks for Excluded Individuals – October 6, 2016

- Federal databases
  - OIG Exclusions list – employees and/or subcontractors – upon hire and monthly
  - SAM – for entities only – upon hire and monthly
- Louisiana database
  - Adverse Actions website – employees and/or subcontractors - upon hire and monthly
- Required to maintain proof that checks were done for employees and sub-contractors
- DSW Registry – every six months – updated requirement in Registry Rule for June 2016
- Information is available in RA messages and Bi-Monthly Provider Updates – available on Louisiana Medicaid website

General Discussion – July 7, 2016

1. What were the major issues discovered in initial EVV implementation?
   a. Providers not meeting the ratio requirements of staff to participants (too little staff for the number of participants served).
   b. Services prior authorized not provided (Supported Employment was prior authorized but Day Habilitation services were provided).
   c. Overlaps within service types – a staff person cannot supervise both Day Habilitation and Supported Employment services at the same time due to the nature of the services.

2. Mandatory electronic clock in/out for Supported Employment and Center Based Respite goes into effect 9/1/16.

3. OCDD is currently reviewing the list of providers who are not using the mandatory electronic clock in/out.

CPOC Documents/Revisions Discussion – January 5, 2017

1. Is a signature required on the provider documents (backup plan, evacuation plan, seizure plan, etc.)?

Answer: The provider documents should be presented and discussed at the CPOC planning meeting with the entire IDT. The signatures of the IDT during the CPOC planning meeting may serve as the signature for the provider documents. All provider documents must be dated to indicate when the document was developed/revised. The LGE has the latitude to require IDT signatures on the provider documents.

2. Is a provider plan of care required even though the CPOC can be used for the plan of care per licensing standards?

   Answer: All OCDD Waiver Manuals currently require both a POC and a completed Individualized Service Plan (ISP).

3. Can providers wait until the end of a PA period to request additional units instead of calling SC for revision every time a participant misses day hab, etc.?

   Answer: As has been discussed and explained multiple times, the provider based on individual needs has the ability to flex units within the specified PA timeframe. If units have been shifted and additional units are needed for the remainder of the quarter than a revision should be completed in appropriate timeframes at the end of the quarter (i.e., routine revisions should be submitted at least 10 days prior to the end of the quarter).

4. Explain ability of providers to flex 100% of IFS units versus requesting a revision.

   Answer: OCDD has worked with SRI to allow for flexibility based on individual needs. This means that if an individual would like to convert IFS supports from single supports to shared supports, this can be accomplished without a revision working within the budgeted dollar amounts associated with the approved units. Converting service units from day program to IFS hours is not able to be done without completing a revision.

Overlapping Services – January 5, 2017

1. How providers should address billing overlaps with other providers. Not always sure how to handle or who to contact if there are problems or unable to resolve between provider agencies.

   Answer:

   A. If the overlap is for a recipient, then the EVV will not block the Day Hab, Prevoc, SE provider. Only the PCA provider will be blocked. If the Day Hab, Prevoc, or SE provider is not using the EVV for electronic clock in/out, then the providers need to work together to resolve the overlap. For overlaps prior to 3/1/16, please contact Kim Kennedy at kim.kennedy@la.gov and provide the following:

      a. Specific overlaps that need resolution

      b. Date you contacted the other provider agency to resolve the overlap.

      c. Who you spoke to

      d. Any agreement made by the other provider.

      e. Kim Kennedy will follow up with the other provider. Please do not request assistance until you have made three attempts to resolve the overlap with the other provider.

B. If the overlap is for a DSW, then both agencies should be talking to the DSW immediately to find out which billing is correct. You can always conference call with the other provider with the DSW in the room to determine whose information is correct. You do not have to reveal the participant's name in the call, just the hours worked by the DSW. The state expects the provider whose information is not accurate based on this call to immediately correct the information in LAST so the billing can be released for the provider whose information is correct.

C. As a reminder to all providers, overlaps are expected to be resolved within 60 days from the date of service per the Memo from Mark Thomas/Tara Leblanc dated 11/16/15.

New Opportunities Waiver Renewal – January 5, 2017

1. Approved effective 1/1/17
2. 90-L is being revised to allow a PCP's Nurse Practitioner or Physician's Assistant sign off on 90-L
3. Employment Related Training renamed Prevocational Services to be consistent with Supports Waiver and Residential Options Waiver
    A. All are the same service
    B. Core Service Definition – Services that provide learning and work experiences, including volunteer work, where the individual can develop general, non-job-task-specific strengths and skills that contribute to the employability in paid employment in integrated community settings. Not primarily directed at teaching skills to perform a particular job, but habilitative goals associated with building skills necessary to perform work. Prevocational services are not an end point, but a time limited service for the purpose of helping someone obtain competitive employment.
        i. Waiver funding is not available for the provision of vocational services delivered in facility based or sheltered work settings, where individuals are supervised for the primary purpose of producing goods or performing services. The distinction between vocational and pre-vocational services is that prevocational services, regardless of setting, are delivered for the purpose of furthering habilitation goals such as attendance, task completion, problem solving, interpersonal relations, and safety as outlined in the individuals' person-centered plan. Prevoc services should be designed to create a path to integrated community based employment.
    C. Time limited to four years. The four year clock starts for CPOCs renewed 7/1/17 and later.
4. Companion Care Services – is in the renewal. Billing mechanism is being developed.
5. NOW Rule is in revision and incorporates some of the settings language. Expected to go out for NOI in February/March 2017.