Liberty Healthcare Corporation of North Carolina

Provider Training May 2019 Questions and Responses

The following questions were posted during the May 2019 Provider Trainings. Questions only cover topics presented during the general session:

- PCS Updates
- Medicaid Managed Care Transition
- Other

PCS Updates

- **Must you go to the client house with the printed online service plan to sign or can you create your own service plan based on section 6.1.4 PCS policy guidelines and upload to the Qi Report portal?** The provider shall ensure that the beneficiary or their legally responsible person understands and, to the fullest extent possible participates in the development of the PCS Service Plan. Once the provider consults with the beneficiary or legally responsible party, they may then develop the service plan to be validated within seven business days of the provider receiving the IAE referral. The provider shall obtain written consent in the form of the signature of the beneficiary or legally responsible person within 14 business days of the validated service plan.

- **Form 3085 is it per agency or per client? How do you upload form 3085 in Qi Report?** The NC Medicaid 3085 Session Law 2013-306 PCS Training Attestation Form is to be submitted per agency/licensed residential facility to attest that staff are properly trained to care for those beneficiaries that are covered in session law. The form can be uploaded by those with Provider administrative user rights for your agency within QiRePort. Select the set-up tab in Qi Report and then select the documents tab to the left. Then click the add button to add a document. The upload screen functions similar to supporting documents.

  Why do clients admitted before 2015 still have no ICD 10 codes and you all are still requesting when you say we don't need? The requirement to submit an ICD-10 ensures compliance with PCS policy as beneficiaries are required to be under the ongoing direct care of physician for the medical condition or physical or cognitive impairment causing the functional limitations requiring the PCS. For beneficiaries admitted before 2015 a current diagnosis is not available signed off by the physician treating the medical condition or diagnosis causing the functional limitation. Providers should refer to their current case load report to view the ICD-10 status. If there is a "yes" in either column of the ICD-10 or New Referral/COS column the ICD-10 is not needed. If both columns read "no" the provider is not compliant with the ICD-10 requirement for that beneficiary.

- **How long are old 3051 forms going to be accepted?** These will be accepted up to July 1st 2019.

- **Can the IA be changed to reflect hours per week instead of monthly hours? This would eliminate any change of hours depending on the # days per month?** No, at this time Medicaid is not looking to make changes to the authorization. Providers are recommended to reference the

training material offered by Viebridge on “Provider Enhancements” and the functionality that will assist with determining how to address fluctuating hours month by month.

- **If a beneficiary changes their mind and wants to go from 7 days a week to 5 days a week of service can those hours be added to the 5 days per week or do, they lose them?** No, a non-medical COS form is needed to adjust the PCS need frequency from seven days a week to 5 days a week. This change will result in a reduction of hours.

- **ICD transition forms- If the annual assessment has the DX with ICD 10 codes, does that mean the requirement has been met?** No, an annual assessment with an ICD 10 code does not satisfy this requirement. This requirement is met when an ICD-10 transition form, new request, or medical COS has been submitted for beneficiaries who were receiving services prior to 10/1/2015. **Can forms be faxed/sent in to Liberty directly from the MD office?** Yes, it may come directly from MD but provider is responsible for verifying that it has been received/ completed.

- **What steps do you need to take to request another assessor for your facility? It appears the current assessor does not hear anything the staff tells her.** Liberty recommends if a provider has a concern to contact the call center for assistance and follow up.

- **Doesn’t the online service plan tool force compliance with 6.1.4?** The online service plan is a tool and its purpose is ensuring the service plan matches the assessment. The provider ensures compliance by meeting the required timelines as stated in Clinical Coverage Policy 3L.

- **How many ICD-10 forms are still missing?** There remain a number of outstanding ICD-10 forms. Medicaid will continue to review numbers and address in the coming months.

  Do you have 21 days total to do a service plan? The PCS service plan must be developed and validated within seven business days of the Provider accepting the IAE referral. The provider shall obtain written consent in the form of the signature of the beneficiary or legally responsible person within 14 business days of the validated service plan. The written consent of the service plan must be printed out and uploaded into the Provider interface.

- **If you are unable to upload a resident’s supporting documents can Liberty withhold your service fees and if yes what can you do to be paid?** Liberty is not involved with holding fees or pay related to providers being unable to or failing to upload service plans. Liberty recommends if you are having trouble uploading it, please call the call center for assistance.

- **Our agency seems to run into issues with billing going over hours when following the exact schedule approved on the care plan summary created in QI. How do we avoid this? We prefer not to do “days off” to avoid patients not losing a day of service if they need someone in the home?** QI Report offers functionality to give providers the tools to ensure the appropriately schedule services based on hours authorized. Days off is not an option for providers. A beneficiary is to receive services based on the need frequency identified in the assessment.

Why can't Liberty RN have beneficiary sign service plan at the same time as assessment? The provider organization shall ensure that the beneficiary or their legally responsible person understands and, to the fullest extent possible participates in the development of the PCS service plan. Liberty healthcare is the Independent Assessment Entity for NC Medicaid, it is the provider's responsibility to review the assessment, consult with the beneficiary and/or their legally responsible person, and then develop the Service Plan.

Medicaid Managed Care Transition

- **Will Liberty still be coming out past July and then past November past Nov 2019?** Liberty is the current vendor for the Independent Assessment Entity for the PCS program. The State has issued an RFP for a Comprehensive Independent Assessment Entity and will accept responses to the RFP. The selected vendor will conduct assessments for those Medicaid beneficiaries still serviced under Medicaid Direct/ fee for service once Medicaid Managed goes live.

- **What about residents who are over 65 but not eligible for Medicare and are Medicaid only for mental health?** Certain Medicaid and NC Health Choice beneficiaries with a SMI, SUD, or I/DD diagnosis and those enrolled in the TBI waiver will be delayed in transitioning to Medicaid Managed Care until Tailored Plans are effective.

- **So, will Liberty, managed care, and agency all go out to assess recipient for service?** The vendor for Comprehensive Assessment Entity for Medicaid PCS program will continue to conduct independent assessments for beneficiaries remaining under Medicaid Direct/ Fee for Service. Medicaid beneficiaries who transitioned to Managed Care will be assessed by the PHP. The provider agency contracted with the PHP will coordinate for assessments.

- **Medicaid recipient does qualify for PCS thru Liberty. Is it possible the may qualify thru the PHP?** The Medicaid beneficiary will be assessed by the PHP. The Plans are required to establish policies consistent with Clinical Coverage Policy 3L. The Plans do not have discretion to require more restrictions than current policy, such as requiring limited hands on assistance with 4 ADLs vs current requirement of 3.

- **What will the assessment process be under the health plans? Does Liberty retain the contract?** The PHPs will have discretion to develop their own process to determine eligibility and Level of Care for PCS. The plans are required to maintain eligibility for approved services prior to time of enrollment in managed care. The plans are required to do an expedited screening and complete a service plan up to 90 days after managed care is effective. Liberty is currently the contracted vendor but the contract is expiring in the next couple months. The RFP for the Comprehensive Independent Assessment Entity is posted, will come down on May 20, 2019 and

Medicaid will determine who the CIAE will be. There will continue to be an Independent Assessment Entity for Medicaid Direct/fee-for-service PCS.

- **How will PCS billing be done? NC Tracks?** For those beneficiaries continuing on Medicaid direct, providers will submit the claim through NC Tracks. For those with beneficiaries who have transitioned to managed care, you will submit claims to the PHP and they will pay those claims. Providers will receive a provider manual for the PHP outlining billing practices for that plan.

- **What role will Liberty Healthcare play?** Liberty is the current contract for the IAE and will continue until the sunset of the current contract for PCS beneficiaries receiving services under Medicaid Direct/fee-for-service.

- **Will LHC still receive the PCS request and have the nurses perform the assessment?** They will continue as the IAE for individuals receiving services under Medicaid Direct/fee- for-service.

- **What is PDC and what is PHP?** PDC is the contracted vendor that will assist Medicaid providers in the credentialing process necessary to be an enrolled provider in managed care. PHP is prepaid health plan.

- **Providers with dually eligible beneficiaries in ACH. Will they have to credential?** Yes, you will need to maintain status as an eligible provider and Medicaid requires credentialing.

- **Region 3 can they also enroll in the other (4)?** The regional description is based on where people live. The providers in region 3 will have option to enroll with all 5 plans since the Provider Lead Entity (PLE) covers region 3 & 5. Providers in regions 1,2,4,6 will not have option to enroll in PLE Carolina Complete Health.

- **What is the website referenced by Sabrena for attendance at the meet and greet for managed care?** www.nc.medicaid.gov. Look for Medicaid Transformation Tab.

- **We have clients spread thru at least 3 regions. Will we run into difficulty with this in our company? Should we encourage existing clients to choose specific contracted entity?** No, you should not have difficulty. Only 1 of the PHPs are limited to serving in region 3 &5. NO, you should not encourage as it is the beneficiary's right to freedom of choice.

- **Will we still be able to bill through NC Tracks after becoming managed care?** Yes, provider will still use NC Tracks for beneficiaries served through Medicaid Direct fee for service.

- **Provider has not gotten credentials, what will then happen with the beneficiary?** The provider's credentialing has nothing to do with the beneficiary. The provider credentialing enables the provider to be an approved Medicaid provider and ability to contract as you see fit with the PHPs. The beneficiary enrollment will depend on if they are a Medicaid beneficiary required to enroll and which plan they chose.

- **We operate 122-C group home for individuals with I/DD. Most of our customers will fall under tailored plans. Do we still need contracts with PHP's for PCS services?** Recommended question to be entered into the Medicaid Transformation website.

- **With managed care action, will Liberty still continue with assessments? Do providers still continue things like QiReport?** The IAE will continue assessments for beneficiaries in Medicaid Direct. Providers with PCS beneficiaries in Medicaid Direct will continue to use QiReport.

- **If you are purchasing a business, will their current credentialing transfer to the new owner?** Recommended to reach out to the Medicaid Provider resources for answer as it depends on the contract purchase.

- **Are we still going to bill thru NC tracks**? Yes, for Medicaid Direct / fee-for-service.

- **If you were recredentialed 8/16/18 will you have to be recredentialed again?** It depends on what you are credentialed as. Providers are recommended to check to make sure everything is correct.

- **When managed care begins, will the managed care providers allow for a family member that resides with the client/ member that resides with the client/member to be the aide to care for the client under PCS?** PCS does not allow identified individuals to be the aide for the beneficiary which will not change with Managed Care.

- **Will the client's enrollment affect the number of monthly service hours they are authorized to receive?** Initially during first 90 days, no as approval remains the same. Beneficiaries will have a comprehensive assessment screening by the PHP that may result in greater or less hours than previously approved. If there is an adverse decision, actually like now, beneficiary continues to have appeal rights.

- **Is it true that billing will only be allowed monthly or can we still bill weekly?** Managed Care billing questions should be directed to the Medicaid website subsection transformation.

- **Does the home health agency assist the member in completing the enrollment of managed care?** No, NC Medicaid instructs providers to direct beneficiaries to contact the Enrollment Broker as it is important the beneficiary exercises their freedom of Choice. The law requires we ensure this occurs.

- **Is it only those that are younger or older that have CAP that can get services?** Community Alternative Program is a 1915 Waiver. NC has 4 CAP programs, CAP Children under age 21, CAP for Disabled Adults for 21 and older, Innovations waiver for beneficiaries with I/DD conditions, and recently added Traumatic Brain Injury. The goal is to offer assistance to these specific populations who are at risk for institutionalization, which will support their needs and allow them to remain in a community setting.

- **Why is it a cost to get assistance with signing up with managed care?** There is no cost for beneficiaries to enroll into Managed Care. NC Medicaid asked that if anyone tells you they will enroll you for a fee, please contact NC Medicaid as this is a scam.

- **CAP users can be what age? Can one be coming out of the hospital today?** CAP recipients can be from 0 to 100+. Individuals, adult, child or infant, coming out of hospital today needing assistance in their home related to their condition can submit a CAP application

- **Is there a fee by the Choice PHP's to utilize and bill on their interfaces?** NC Medicaid recommend this question be submitted to the NC Medicaid Managed Care Transformation website.

- **Are there opportunities for new provider due to changes with managed care?** Depends on if

provider is interested in becoming a new PCS Provider. The current moratorium on Homecare license is in place until end of June. If this continues, no new PCS agencies may open. If the provider is interested in the recent DHHS Demonstration Waiver, Innovation related. With this Health Plans are able to provide "in lieu of services" such as home and vehicle modification. This could be a new service for providers.

- **Is it mandatory for the member to enroll if they do not what will happen?** It is mandatory as law as enacted by NC General Assembly that if a Medicaid beneficiary wishes to participate and receive services, they must enroll into Managed Care by selecting a PHP or they will be auto enrolled if they have not selected by a certain date.

- **Will customers on Medicare not Medicaid who have Humana insurance be eligible now for PCS using managed care?** State Plan PCS is a Medicaid funded program. The beneficiary must have Medicaid in order to receive PCS services.

- **Can PHP's recommend agencies?** The beneficiary has the freedom of choice to select their agency. The PHPs are instructed to accept the provider of choice to deliver services for the beneficiary.

- **Who chose Maximus to be a representative?** A bidding process for an RFP posted this Fall 2018. Maximus won the contract as Enrollment Broker for Managed care.

- **Are you saying Liberty is going away?** No. **Will Maximus be taking Liberty's place?** No. Liberty has a contract with NC Medicaid as the Independent Assessment Entity to complete the face to face assessments for PCS to determine eligibility and level of service. We have had a contract since 2013 and the terms of the contract ends at some point the end of this year. NC Medicaid has posted an RFP for interested contractors in doing this work. The IAE who is currently Liberty will continue. Liberty will not be doing assessments for members enrolled in managed care. Each PHP will have a process for determining eligibility and level of service. NC Medicaid will continue doing assessments for beneficiaries still in Medicaid Direct.

- **Do we go through Maximus to get paid?** No, Maximus is the Enrollment Broker who will provide assistance to Medicaid beneficiaries in selecting a PHP and getting enrolled. Providers who provide PCS through Medicaid Direct will continue billing through NC Tracks. Providers who will be providing PCS for Medicaid beneficiaries transitioned to Managed Care will bill the PHP.

- **How would we as a provider know what managed care company, they chose such as BCBS? We currently get notifications through QiReport**. There are a couple ways…1) beneficiaries receiving PCS through LTSS will be assigned a care management entity and will likely reach out to the provider currently serving beneficiary. 2) a link will be posted for providers to access to determine. IT should also be available in NC Tracks. Beneficiaries that do not enroll will be auto-enrolled in a plan beginning mid-September.

- **Will some members be transitioning from PCS to mental health tailored plans?** Medicaid beneficiaries enrolled in tailored plans will not transition until July 2021, therefore these beneficiaries will remain on fee for service until tailored plans are initiated.

- **Who are the 4 or 5 representatives for each region?** AmeriHealth Caritas, Blue Cross Blue Shield, Well Care, and United Health are statewide PHPs. Carolina Complete Health is the provider lead entity (PLE) for region 3 & 5 only.

- **Where is the State on approving the MCO handbooks/policies?** The State continues to review PHP policies for approval. This process will be complete closer to go-live.

- **Do PHP'S have specific contract departments we can contact to initiate Contracts?** Please visit the NC Medicaid website and search for Medicaid Transformation for additional information.

- **Under managed care, if a client receives Blue Cross Blue Shield would they now qualify for PCS, because prior to now, PCS services was only reimbursement by Medicaid?** There is no change to the eligibility requirements for receiving PCS.

- **How does this affect VA dual qualified? Are they carved out?** NC Medicaid recommends this question be submitted to the Medicaid Transformation Website.

- **Should providers enroll in more than 1 network or all networks?** NC Medicaid cannot direct provider on enrollment. Providers are encouraged to participate in Managed Care Provider Trainings for additional information.

- **If someone is Medicaid only now but becomes dually eligible with the 4-year period will they stay under managed care?** Beneficiaries that are currently Medicaid only and meet the requirements for Standard Plan transition will be required to enroll in Managed Care. If the beneficiary becomes Medicare eligible while under Standard Plan Managed care, they will be disenrolled and re-enrolled into Medicaid Direct fee for service as they are now considered dually eligible.

- **Under managed care will there still be a check-write weekly?** Managed Care billing questions should be directed to the Medicaid website subsection transformation.

- **How long will it take managed care providers to process claims?** Managed Care billing questions should be directed to the Medicaid website subsection transformation.

- **All of my buildings are Medicaid. Residents are dual eligible. Are we required to enroll with the MCO'S?** I know that doing so would not likely allow us to receive a straight Medicaid eligible resident in future? Enrolling with the PHPs will not impact the type of resident you receive in the future.

Other

- **Does EVV apply to Assisted Living and FCH providers?** No.

- **Is the satisfaction survey required for the beneficiary and the legally responsible person? Or can it be one or the other?** It can be the beneficiary if he/ she is able to participate in the survey. Otherwise the legally responsible person would complete.

- **Why do the IAE tell patients that aides can do house cleaning (non- covered tasks)?** If the beneficiary demonstrates a need for hands on assistance of limited or greater in the ADLs, they can receive assistance with IADLs for the ADLs that they need hands on assistance with as part of their plan.

- **Are FL2's required to be done every year?** See N.C. DHSR.
- **How many Alzheimer's module should be done for training?** There are no required number. The provider must comply with submission of the NC Medicaid 3085, listing the trainer and curriculum.
- **MQBQ? What causes the delay?** MQBQ does not cover State Plan PCS.
- **Based on the IA done a client received 3 extensive which according to policy need a Certified Nursing Assistant. The client previous annual required a PCA. Now the client wants to keep his previous aide and not change to C.N.A. The client call Liberty stating he wants his PCA, he is told by Liberty that your provider can let you have the aide you want. What do you do? P.S. the client does not need a CNA some things on the assessment didn't represent the client correctly.** Provider must follow all licensure requirements, based on the beneficiary's needs as identified on the assessment. IF the provider feels the beneficiary's needs have changed, a COS would need to be submitted for another assessment.
- **For CAP DA clients, if a CNA works with a client for 8 hours are they required to take an hour lunch break? If yes should that be documented on the timesheet?** This is not a Medicaid policy. Providers should refer to the NC and Federal Labor Law. Providers are recommended to refer to your organization's policy as well.
- **Can a LPN do quarterly visits for a client?** No, Clinical coverage Policy 3L Section 7.10 b. states that the in-home PCS provider shall ensure that a qualified RN Nurse Supervisor conducts a RN Supervisor visit to each beneficiary's primary private residence location every 90 calendar days.
- **Who do we call for technical problems?** If related to credentialing, communicate with NC Tracks. If related to PCS, contact Liberty Healthcare. If related to Qi Report, contact Viebridge.
- **How do we contact Viebridge?** The contact information is listed on QI Report website. You may email, submit your question, or call them directly.
- **How will EVV work in rural NC where no cell phone service and the client may not have a home phone?** The EVV systems will allow for time entries even if there is not a connection. It will store the information and when the staff enter an area with a connection it will complete the action. The vendors will demonstrate how this will allow for service in rural areas during the selection process.
- **Do you anticipate PCS reimbursement rate increasing soon?** The State is not aware of a rate increase at this time. Providers are recommended to share concerns with their Legislators.
- **Is the provider required to sign the completed service plan?** The staff person completing the plan is listed on the service plan. No additional signature is required from the Provider.
- **Will the State charge providers for the use of the EVV**? The State does not anticipate a high cost for this. There may be a minimal cost but the State will consider the least burdensome method.
- **Can the hours approved be used to bill for nursing admissions and supervisory visits being that there is no billing code for nursing?** No, the approved hours are for the approved ADL services for the beneficiary.

- **If EVV providers meet regs can provider select any provider or only ones approved by State?** Providers may select their own system as long as it meets the requirement for the 6 data elements and electronically submits to the State. The State will only procure one system. Providers can use the State procured or their own.

- **If our system allows the telephony is that excepted by the State as EVV?** The requirement is the system must collect the 6 data elements. As the State moves closer to EVV effective date, if the provider's system supports pulling those data elements and have the capacity to electronically submit to the State it is possible it will be considered. Basic telephony systems that do not have support to the collection and submission will likely not meet those needs.

- **So, since proof of services is in real time how quick is verification for billing is proved? This** is an electronic process, automated and immediate. We will consider deviations such as, you have a schedule for 10a-12noon, the beneficiary goes to MD, and so the caregiver will come in early. These will be considered deviations to be documented. Another example is the aide will forget to clock in. The provider will be responsible for reviewing and verifying prior to submitting and billing.

- **Will agencies still need to use manual time/task sheets once EVV is implemented?** EVV is an electronic process but you may continue to use manual timesheet. The State will look for the system to only collect the 6 defined data points so it will not serve as your payroll, timesheets, etc.

- **Will the agency be responsible for implementation of the "open vendor model" in beneficiary's house? Or the State?** This is a Federal Requirement and beneficiaries wanting to receive PCS services, they will be required to comply with EVV. The open vendor model means the State will purchase a system. Providers may continue to use what they are using. There may be some cost but it should be minimal.

- **The rule requires that PCS be provided for days of the month. We manually adjust calendars to cover the "extra" days on longer months. Can the methodology or calculation be revisited to account for home care agencies not being paid but required to provide services to remain in compliance?** There should be no days that an agency cannot be paid for hours authorized. Contact NC Medicaid for additional assistance with how to manage and schedule authorized PCS hours.