Tribal ALTCS QTR Meeting Minutes.
August 26, 2021
9:00am
Meeting Held via "Google Meets"

Meeting Start Time: 9:05am

- **Rachel Hunter**: Project & Policy Updates & Tribal ALTCS
- **Kevin Hoy**: Deliverable Reports and Network Stats
- **Soni Fisher**: Open Line Request Form
- **Cheryl Begay**: Member Change Report & AHCCCS EI Updates
- **Vanessa Torrez**: PA & Claims Process for Customized Wheelchairs

Morning prayer: Conducted by Marie Keyonnie

Project & Policy Updates by Rachel Hunter (TRIBAL ALTCS Administrator)

Person Centered Service Plan (PCSP):

Trainers should be providing training and resources to their Tribal ALTCS Case Managers. All the necessary tools were provided to support the supervisors to train their case managers. The same information was presented to the MCOs and is utilized across all ALTCS Health Plans.

Barriers Identified by the Tribal ALTCS Programs:

- Northern Arizona Members are not able to complete the Review Assessment due to not having enough phone minutes. A lot of members have set minutes on their phone plan or on the free government issued phones, they do not have unlimited minutes. This information was shared at the Executive Management at AHCCCS.
- Assessment takes too long and members need a break or become disengaged so CM must break up the review assessments which can sometimes take more than day to complete a review assessment.

Surveys Results:

- AHCCCS received a response from 4 Tribes.
- Survey results shows that Tribal ALTCS Programs need additional training in the following areas: Risk Assessments, Goals, and Action Plan.

Policy Updates:

AMPM Approved Policies

- 02/04/21 - 961, Incident, Accident, Death Reporting
- Published 04/01/21
- 03/04/21 - 1620-O, Abuse, Neglect, and Exploitation Reporting Standard
- Published 05/03/21
- 04/01/21 - 1620-G Behavioral Health Standards
- Published

- 05/20/21 - 1630 - Administrative Standards & Attachment A Case Management Plan Checklist
- Published

Policies that are now open and workgroup is currently reviewing

- AMPM 810 - Fee-for-Service Utilization Management
- AMPM 820 - Fee-For-Service Prior Authorization Requirements
- AMPM 1620-F Tribal Fee-For-Service Standards

Tribal ALTCS Program leadership and Case Managers should review the updated policies.

Prior Authorization Request Updates:

- DME (Durable Medical Equipment) **DOES NOT** require PCSP
- Home Mods **DOES** require the PCSP

Supervisors need to share this information with their Tribal Case Managers.

EVV Updates:

Some of the providers are not participating in the FFS Provider Cohort meetings. There are a few providers who have not started or completed the EVV Sandata Training Modules. Previous Tribal ALTCS Quarterly meeting we had 32 FFS providers who had not complete the Sandata training. As of today, there are only 14 providers who have not completed the required trainings and one provider on the list has been terminated.

Some ideas implemented at the Tribal level since the last meeting.

- Notify Tribal Business office
- Add a comment to referrals sent to Direct Care Agencies

Providers that have not started the EVV trainings.

DIRECT CARE AGENCY	PROVIDER ID
Cedar RIDGE HOME CARE	631940
COS 1 LLC (T)	993405
DOG SPRING HOME CARE	807065
HASHINEE' HOME CARE	873427
HOME CARING LLC (AHCCCS made contact and will follow)	**398994**
HOPE HOME CARE	160608
OOBA HOME CARE (AHCCCS made contact and will follow)	**380918**
MOUNTAIN VIEW HOME CARE	908392
PINE VIEW HOME CARE (AHCCCS made contact and will follow)	**549584**
SACRED HEARTS	162473
TOWERING ROCK NON-EMERGEN	163119
TSIN-NAN-TEE	467942
UNITY CARE LLC	163218
WHISPERING SHADOW CARE LL	401386

EVV Requirements and Information is available on this link:
https://www.azahcccs.gov/AHCCCS/Initiatives/EVV/

Supervisors need to share this information with their Tribal Case Managers.

Deliverable Reports and Network Stats – Soni Fisher and Cheryl Begay

Caseload Ratio Report – forms are in the digital box.

AMPM 1630 Administrative Standards - This is related to our tribe and native health.

A. Case Manager Qualifications
Section D-Caseload Management

Caseload formulas

(# of members in an institutional setting x 1.0) ***Max member caseload is 96***

(# of members determined to have an SMI who are in an institutional setting x 1.4) ***Max member caseload is*** 68

(# of members in an HCBS (own home) setting x 2.2) ***Max member caseload is*** 43

(# of members determined to have an SMI who are in an HCBS (own home) setting x 3.0) ***Max member caseload is*** 32

(# of members in an Alternative HCBS setting x 1.8) ***Max member caseload is*** 53

(# of members determined to have an SMI who are in an Alternative HCBS setting x 1.9) ***Max member caseload is*** 50

(# of members in Acute Care Only (ACO) status x 1.0) ***Max member caseload is*** 96

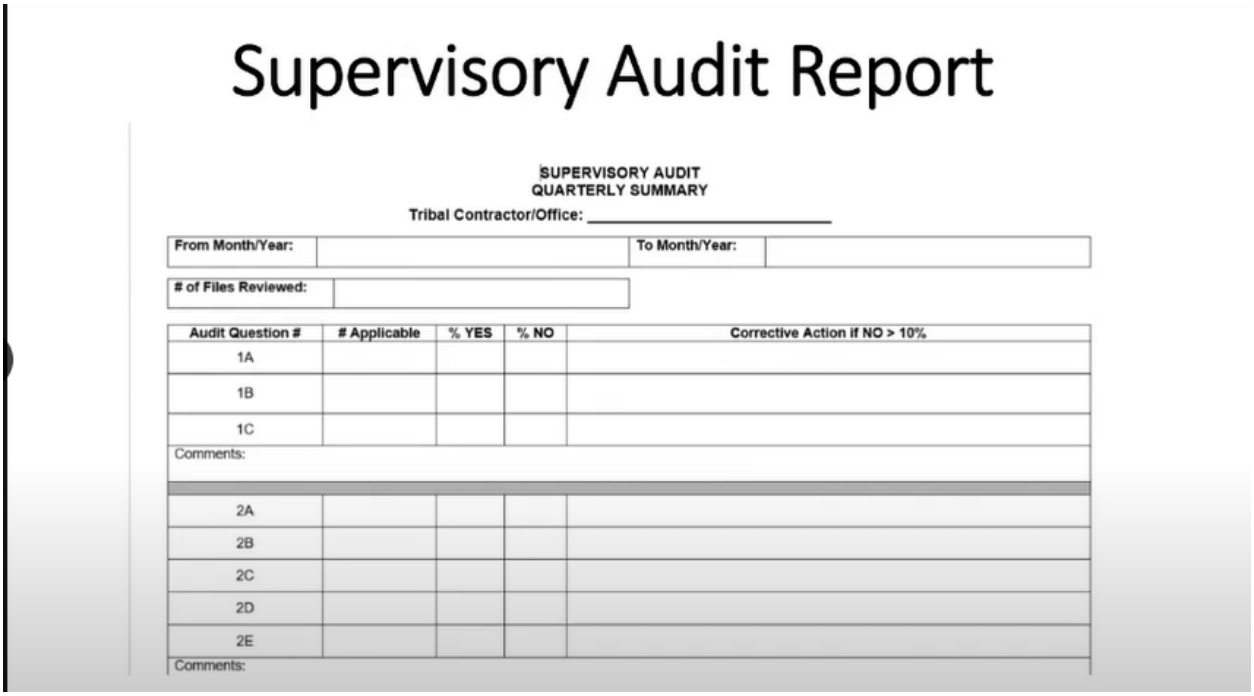
(# of members determined to have an SMI who are in Acute Care Only (ACO) status x 1.0) ***Max member caseload is*** 96

No matter the mix, the caseload ratio must be under 96

Network Quarterly Report Stats-Caseload Ratio

- Submission 'on time rate': **87.5%**
- Use of new form: **100%**
- Total number of Network CMs: **90**
- Average per plan: **8.5** (excluding NN/with NN included 11.25)
- Network caseload average:
  Range from 18-71 members (affected by staff vacancies)
  Average is 37.9 members per CM
- Network weighted value: (affected by staff vacancies)
  Average 58 (max is 96)
  Range 31 to 97.4

Supervisory Audit Report – The Supervisory Audit Report on the AHCCCS website, Digital Toolbox is the most current version and looks like the snapshot below:



Supervisory Audit Report

SUPERVISORY AUDIT
QUARTERLY SUMMARY

Tribal Contractor/Office: _____

From Month/Year:		To Month/Year:	

# of Files Reviewed:	

Audit Question #	# Applicable	% YES	% NO	Corrective Action if NO > 10%
1A				
1B				
1C				
Comments:				
2A				
2B				
2C				
2D				
2E				
Comments:				

AMPM 1630 Administrative Standards

A. Case Manager Qualifications

A system of internal monitoring of the case management program, to include case file audits and reviews of the consistency of member assessments and service authorizations shall be established and applied, at a minimum, on a quarterly basis.

Results from this monitoring including the development and implementation of continuous improvement strategies to address identified deficiencies shall be documented and made available to AHCCCS upon request.

Network Quarterly Report Stats- Supervisory Audit.

Supervisory Audit

- Submission rate per month: 87.5%
- Average of total files reviewed: 30 files

  Range: 11 files to 76 files
- Average percentage of total membership: 20%

  Range 2%-46%
- Plans entering 100% for <1 questions (up to 43 possible questions to answer):

  2 plans answered only 1 question as non-compliant

  2 plans answered all questions with 100%
- Range of audit reports with a NO and comment:

  0-16
- There should be questions answered with NO, indicating an opportunity for performance improvement for your staff.

Example; *Was a Member Change Report submitted for all member changes (ie: address, placement, etc)? If this didn't occur, it's a NO. Schedule time to train the staff how to file an eMCR and when this is required.*

Supervisory Audit-Helpful Suggestions

- Ideas in how you determine how many files to review?
- What do you do when the results from the file review indicates a case manager needs performance improvement assistance?

Open Line Request Form – Soni Fisher

Soni in the Tribal ATLCS team has created a fillable pdf Open Line Request form, which is located in the Digital Toolbox under Common Forms on the AHCCCS website (see link below).

https://www.azahcccs.gov/AmericanIndians/LongTermCareCaseManagement/CaseToolManagementDigitalToolBox/digitaltoolboxallaboutforms.html

- The reason we need both the Case Manager and Supervisor to sign is that we have received calls from numerous Providers asking why AHCCCS is recouping funds. It is the responsibility of the Case Manager, when they submit an OLR, to notify the Provider that AHCCCS will be recouping the paid funds as corrections need to be made to a service line, and that the Provider will need to resubmit claim(s) in order to be paid.
- A Supervisor's signature is attesting that he/she has reviewed and approved the OLR. In addition, it is their attestation that they have confirmed with the Case Manager that he/she has notified the Provider(s) that changes need to be made to the service line and AHCCCS will be recouping the paid funds. Therefore, the Provider will need to resubmit the claim(s).
- Tribal ALTCS Case Management Coordinators will place comments on CA165 **only** if the OLR is missing something, incomplete, etc., and include instructions on what the Case Manager needs to do.
- There is a statement below the signature line which reflects:

NOTICE: CASE MANAGER TO PERIODICALLY REVIEW THE CA165 COMMENT SCREEN FOR STATUS UPDATES FROM AHCCCS TRIBAL ALTCS REGARDING THIS OPEN LINE REQUESTS.

- This Open Line Request form will go into effect **September 1, 2021** (throughout all Tribal ALTCS Programs) and is to be completed/included with every OLR that is submitted to AHCCCS.

ALTCS Member Change Report – Cheryl Begay

ALTCS Member Change Report User Guide – Link to create an account and login:

https://www.azahcccs.gov/PlansProviders/Downloads/ALTCSMCRUserGuide.pdf

ALTCS MCR User Guide:

- Reference AMPM Chapter 1600, Exhibit 1620-2 for guidelines on when to use a member change report form.
- https://azahcccs.gov/shared/Downloads/MedicalPolicyManual/1600/1620-2.pdf

An electronic Member Change Report (eMCR) shall be sent to AHCCCS to report or request the following:

- To report a change in the member's demographic data (for example, address, marital status, name change, etc.).
- To report a change in the member's financial status (or that of his/her household) which may affect their Arizona Long Term Care System (ALTCS) eligibility, including the initiation of the member's spouse as the paid caregiver.
- To report a change in an ALTCS member's placement.
- To report a change in the member's DDD status and request a Pre-Admission Screening (PAS) reassessment.
- To report the closure of a member's service plan for reasons other that financial or medical eligibility (for example, the member dies, moves out of the state, or voluntarily withdraws from the program).

EXHIBIT 1620-2, ALTCS MEMBER CHANGE REPORT Cont.

- To initiate a Contractor, change for a member who is Elderly and/or has Physical Disabilities (E/PD), moves into another Contractor's service area, and resides in a Home and Community Based (HCB) setting (does not include alternative residential settings).
- To request a PAS reassessment when the case manager thinks the member no longer meets medical eligibility criteria for either the ALTCS or Transitional programs.
- To request a PAS reassessment if a Transitional eligible member has a deterioration of condition and will be/has been admitted to a nursing home or Intermediate Care Facility (ICF) and is expected to stay more than 90 continuous days (this request must be sent within 45 days of admission to the institutional setting).

- To request an Acute Care Only determination for a member who has received no Long-Term Care (LTC) services for a full calendar month because s/he refuses ALTCS covered services but s/he has not signed a Voluntary Withdrawal. "Refusing" includes being unwilling or unavailable to receive services offered or covered by the Contractor (examples: member is not home whenever provider comes to deliver care, member unwilling to move out of non-contracted alternative residential setting or member is temporarily out of a contractor's service area). This determination could result in the member being disenrolled from ALTCS if his/her income exceeds 100% of the Federal Benefit Rate.

- To request a change in a member's status from Acute Care Only back to full LTC when the member begins to accept LTC services.

- To request a change in Contract Type when a member has received no LTC services for a full calendar month, due to no LTC service provider being available. This change will not cause a member to be disenrolled.

- To inform ALTCS when a member is temporarily out-of-state (>30 days).

- For Maricopa County E/PD members only – to report the member's request to change Contractors and the need for an enrollment choice.

- To report loss of contact with the member.

NOTE: Members who are temporarily out of the Contractor's service area including out of state, may be provided with LTC services if these are available, in the member's best interests and are approved by the contractor. No AHCCCS services may be provided while a member is outside of the United States.

A hard copy MCR may be needed if, at the time of submission, the member is no longer enrolled with the Contractor that is attempting to send the report.

AHCCCS Eligibility – Latest Updates

The PHE has impacted the way we process some eMCR's. Below are a few examples of changes.

- Cannot discontinue for loss of contact
- Cannot discontinue for moving out of state unless we have an out of state address or we are able to confirm with member they have moved
- Cannot reduce coverage from full ALTCS to acute for any reason, such as refusing HCBS
- If AHCCCS EI receives a report that a customer is over resource or income they are unable to discontinue eligibility.

Staff should be replying to eMCR's to explain when they are unable to make requested changes, that are being put on hold due to the PHE.

Tuba City – Question: On the example. What if the member was admitted 7/16/21 in the evening and services S5125 provided in the AM.? How does that get entered and processed?

Cheryl – Answer: The DCW would be paid for the day 7/6/21. The A23 hospitalization would start on 7/7/21. Each member case may differ. Staff with your supervisor.

Tuba City – Nursing home. In majority of the cases the paid provider is family and want to get paid. They get the person ready to go the SNF. Real situations they want to get paid.

Dedra DeCorse – For NH – anytime a member and/or family/fiduciary is contemplating home to alf/snf placement – we encourage IFS or Tribal Senior services or CHR's to provide care support due to the duplication of services.

Tuba City – Question – Example, let's say. A client is out of state for 3 weeks, the daughter is provider and doing care out of state. Services continue?

Rachel - Answer: The CM needs to educate the member regarding the 30 days exception and monitor closely.

Tuba City – Question: If they come back for a day or 2 than go back to the out of state for another 3 weeks. Kayenta and Dennehotso is near Utah and NM. We had a few cases in the past that this was happening and possibly may comes up again.

Rachel – Answer: What is the reason for them going back and forth? This could become an issue.

PA & Claims Process For Customized Wheelchairs – Vanessa Torrez

Medicare/Third Party as primary

- DME covered by Medicare/Third Party

Medicare Approved Setting
-No Pended PA
-No BID needed

*DME not covered by Medicare/Third Party (Valid Denial Required)

SNF Members
-Pended PA
-EOB
-Delivery Ticket

Customized Wheelchairs:
Medicaid PA Required – **YES**
Bill Medicare as Primary – **YES**
Delivery Ticket – **YES**
Primary Insurance EOB Required for Medicaid as Secondary Payment - **YES**

Any PA/ Provider issues involving PA or requests submitting to Docuware please direct to:

Vanessa Torrez: 602-417-4169 & Vanessa.Torrez@azahcccs.gov

Tuba City – Question: Checking PA online do the DME providers & supply providers have the ability to check these?

Vanessa – Answer: Yes, they do.

Tuba City – Question: Some providers say they don't have the ability.

Vanessa – Answer: Vanessa said direct the provider to her.

Cheryl Begay – It is good provider practice for the providers to keep up on Provider Registration, Training, etc. Provider Portal is provider specific with username and password which the provider sets up.

Tribal ALTCS Projects & Initiatives – Rachel Conley

Turn Around Time Report – Administrator and Manager monitors the report weekly

Creating a new TAT Report

Documents	Subtotal
>80%	23
ALF BH	273
Contractor Change	4
DME	811
E1399	2
Home Modification	97
Open Line Request	451
Out of State Placement	49
SNF	343

Total: 2053 Documents

- FAX
- Duplicate Documents
- Missing Information
- Approval Letter
- No PA Required
- Canceled
- Other Comments

Create Standized Comments:

- Incoming FAX (PA Request)
- Saving Approved Request in Docuware:

Standard comments will help the team identify areas:

- Need improvement
- Provide additional training
- Number of responses provided (FAX/Email)