NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
BISMARCK, NORTH DAKOTA
April 27, 2012

PI 12-05

TO: Regional DD Program Administrators; Regional DD Program Managers; DD State Office; Karen Tescher, Medical Services; Maggie Anderson, Medical Services; Debbie Baier, Medical Services

FROM: Tina Bay, DD Director

SUBJECT: DD Division Policy

PROGRAMS: Extended Home Health Care

EFFECTIVE: **Immediately**

RETENTION: Until Manualized

Description

Extended Home Health Care (EHHC) is a service covered in the North Dakota 1915c DD Traditional Waiver (ND. 0037. R06.02 4.1.2011). The service is an extended state plan service and is available when an eligible participant living with a primary caregiver continues to exceed the limits of Home Health Care available under the Medicaid State Plan.

The amount of Home Health services allowed under the Medicaid State Plan is based on the highest monthly Nursing Facility Rate.

The highest monthly NF rate is updated annually on January 1st.

As of 1-1-2012, the highest monthly NF rate = $17,671

Scope of Service

- The Person Centered Service Plan must address health and safety issues and support Extended Home Health Care (EHHC) as a service necessary for the eligible participant to remain in a family home setting in their community.

- In accordance with 42 CFR 441.301(b)(l)(ii), waiver services, which includes Extended Home Health Care services, are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/ID.

- Extended Home Health Care Service is not available to participants receiving Residential Habilitation.

Eligibility

Individuals must meet all of the following criteria:

- Eligibility for DD services per NDAC 75-04-06;
- Medicaid eligibility
- ICF/ID level of care;
- Living with a primary caregiver, and
- Maximized the amount of home health service available under the Medicaid State Plan.

Service Delivery Method

- Provider Managed

Provider Qualifications

- An Extended Home Health Care Provider must be certified as a Home Health Care provider under Medicare, or a Licensed Provider of Family Support Services.

- Extended Home Health Care Services may be provided by a relative, but cannot be provided by a legally responsible person or legal guardian.

- Extended Home Health Care Services cannot be provided by an individual living in the same home as the eligible consumer.

Key to abbreviations:

- MS – DHS Medical Services
- DDD – State Office/CFS Administrator or other designee
- DDPM – Regional, assigned DDPM

- DDPA – regional DDPA
- Provider – home health provider ("FSS provider" will be specified if also involved)

I. Identification of Potential EHHC Consumer

This service is generally one that is requested only when Home Health costs are exceeding limits set by Medical Assistance (MA) through the Medicaid State Plan and the consumer is on the DD Waiver as noted above.

- *It is assumed that the individual is already receiving DD Waiver services and on Medical Assistance in this document but if that is not the case, those steps (waiver slot request done, etc.) need to occur as well.*

- *Screening code for the Traditional Waiver is "G"*

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a. MS staff will contact the DD Division via email or phone as soon as they receive a request that exceeds the limits of HH under the Medicaid State Plan to determine if the individual is eligible for DD and waiver services. The initial notification is to alert the DD Division and regional DDPA that a transfer to EHHC may be warranted in the near future.

- HH through the Medicaid State Plan will be authorized for a period of 60 days provided criteria are met.

b. MS staff will contact the DD Division and regional DDPA at the beginning of the next authorization period if it is anticipated that the need for Home Health will continue to exceed the limits of the Medicaid State Plan.

- HH through the Medicaid State Plan will be authorized for a second period of 60 days. However,

- **At of the end of the 2nd 60-day period, is expected that the transfer to EHHC-DD waiver will be completed. HH through the Medicaid State Plan will terminate at the end of the 2nd 60 day period and EHHC waiver will be authorized starting the next day.**

c. MS will send the DDPM the most recent authorization for HH Medicaid State Plan to include the start/end dates, number of hours approved and provider currently providing HH.

- It is at this point that the DDPA and DDPM will initiate the steps necessary to transfer the individual from HH MA State Plan to EHHC waiver. (See Service Coordination section below.)

d. MS will send letter notifying family and home health provider of pending change and DDPA will receive a copy.

II. Service Coordination

a. With Family
DDPM will contact family to review current service plan, negotiate EHHC service provider and discuss any changes they might anticipate which may result from this change.
- Family will need to confirm choice of provider who can fulfill the number of hours needed with properly credentialed staff. This may be a DD licensed provider (if nursing resources are available) but is likely to be a home health provider agency.

- Emergency backup/risk assessment plan to be completed with family at this time.
    - It is possible to have EHHC and FSS (Level I and/or II) concurrently with different providers but specific schedules, transitions, and substitute plans need to be well defined between all players.
    - The emergency plan must include a discussion and indicate who will be available for back up in the event the provider is unable to fill a scheduled shift. If the family/legal decision maker does not have an alternate caregiver or other back up plan is not available, the family must understand that they are responsible to cover that time frame.
- ISP completed to add additional service or providers as needed.
    - May be incorporated in Individual Family Service Plan (IFSP) or Person Centered Service Plan (PCSP) if already existing.

- <u>PCSP requirements which need to be met:</u> Risk assessments/ISP/EHHC Authorization/Emergency Backup plan.

b. With EHHC provider
- Contact provider to request "485" data, which includes nursing Care Plan, Dr's order for Home Health Care, and 60 day summary

- Confirm that they have billing manual to do web transfer billing through the DD system and review authorization process & contact person for future activity. (Linda Babcock is contact and will provide this info but needs to be notified by DDPM or DDPA if manual needed.)

- Review decision and reason for change as they should have received letter from Medical Services.

- Review the emergency back- up plan and procedures

c. With Other Primary (IFSP or FSS services)
   - Incorporate Nursing Care Plan into current PCSP/IFSP. Priority goals and activities should be consistent in the nursing CP and IFSP/PCSP.

   - Review the emergency back -up plan.

III. Authorization

- **DDPM must confirm that the individual is eligible for Medicaid at the time the authorization is written. Verify with the family/legal decision maker to confirm a Medicaid approval letter has been received or check the Medicaid Verify System (328-2891 or1-800-428-4140). See last page of document for instructions. The DDPM may also contact the county eligibility worker responsible for Medicaid eligibility determination**.

- Ensure the ISP is accurate and the Case Action Form ICF/MR level of care completed. Payment for services cannot be made unless individual is MA eligible and the ISP and authorization are in place.

- Complete Extended Home Health Care authorization in Therap

- DDPM to contact DDD for provider number.
- DDPM to consult EHHC provider to confirm rate for Home Health Care. and complete authorization. Work flow process then moves ahead.

- Provider to sign authorization and return copy to DDPM. Billing done within 30 days of end of service date.

- Step-On for EHHC providers who are NOT DD licensed providers done administratively based on remittance. DD licensed providers share hours for quarterly Step-On as is current policy.

IV. <u>Monitoring and Follow Along</u>

a. DDPM

- HCBS waiver guidelines followed – 90 day face to face visits, QER
  - Review Medicaid status during contact as well as satisfaction with services, schedules, staff etc. on quarterly basis.
  - (include to EHHC provider unless it is requested to NOT be sent), etc.

- Quarterly or less for authorization.

- ICF/MR level of Care (Case Action Form) Screenings reviewed and protocol followed and appropriate referrals made at that time and term of screenings guidelines.

- Annual PCSP/ISP

b. Family

- ISP and Rights reviewed.
    - Note required MA participation initial and annual redetermination and
    - Follow up quarterly visits by DDPM in particular.

- Return signed authorization and ISP and participation in meetings/completing documents as needed.

c. Provider

- Nursing Plan, doctor's orders

- Authorizations and ISP's will require signatures and need to be returned on a timely basis so payment is not interrupted.

V. <u>Managing Hours and Modifications to current Authorization</u>

- **It is the responsibility of the family/legal decision maker and EHHC provider to know how many hours are authorized for the period and to track the hours that are being used to ensure that the authorized amount will meet the individual's needs during that period.**

- **If the hours need to be increased during the current authorization to meet the health and safety needs of the individual, it is imperative that the family/legal decision maker and/or provider notify the DDPM BEFORE the additional service hours are provided. The DDPM must pre-approve the additional hours by modifying the authorization to increase the hours before they are delivered and document the reason for the increase in progress notes.**

- **Hours exceeding the approved hours on the authorization will not be reimbursed by Medicaid. In addition, authorizations cannot be**

backdated. The communication with the DDPM to request additional hours must be done at the time the additional hours are actually needed, not during the step-on audit process.

- *Example1: An EHHC nurse will unexpectedly be taking a shift because the child is at home ill and cannot attend school. The EHHC provider will email or phone the DDPM so they can discuss the reason for the additional hours and the DDPM can determine whether the hours will be approved and the authorization modified to reflect the increase.*

- The EHHC care provider will also submit a monthly usage list to the DD Program Manager to assist in the monitoring of the amount of service being provided.

VI. Termination of EHHC/Return to Home Health Medicaid State Plan

When an individual is receiving EHHC, and the amount of service no longer exceeds the limits of the MA state plan, AND it is expected the level of service will continue, the process to terminate EHHC and transfer services back to the MA state plan is as follows:

- DDPA or DDPM will initiate contact with MS and DD Division via phone or email when it is anticipated that the amount of service no longer exceeds HH limits under the Medicaid State Plan.
- Region, State DD and MS will discuss return to Medicaid State Plan and determine when EHHC will terminate and HH MA State Plan will start.

- Written notification to individual/legal decision maker must be provided 30 days prior to the termination of EHHC, informing them of the date of termination for EHHC and their right to appeal. A copy sent to MS**.**

  - If a request for appeal and fair hearing is made within 10 days of the date of the notification letter the individual may chose to continue to receive EHHC until a hearing decision is made. However, the written notification must inform them that they may be responsible for the cost of services provided if the state's decision is upheld.

North Dakota Medicaid Verify system

- VERIFY is a recipient eligibility verification system provided by the ND Medicaid program for providers. This system allows the provider to enter the patient identification number using a touchtone telephone and receive a verbal response from the computer indicating the name and date of birth of the patient; the patient's eligibility for a given date of service; Coordinated Services Program information; existence of any third party liability (TPL); and if so, the name of the TPL carrier and the TPL policy number; amount of recipient liability, if any; co-pay; date of last eye exam, frames and lenses, and also the name of the primary care physician (PCP). All responses reflect the latest information available on the data base at the time of the call.

The steps necessary to use the VERIFY are as follows:

For All Voice Responses

1. Dial (701) 328-2891 or 1-800-428-4140 (Receive Message)
2. Enter PROVIDER NUMBER and PRESS # (Receive Message)
3. Enter PATIENT ND MEDICAID ID NUMBER and PRESS # (Receive Message)
4. Enter DATE OF SERVICE and PRESS # (Receive Message)
5. Enter "2" if no more inquiries and to end call, OR,

Enter "1" for additional inquiries and repeat 3 and 4 above.

For Speed Dialing

1. Dial (701) 328-2891 or 1-800-428-4140 (Receive Message)
2. Enter PROVIDER NUMBER and PRESS #, PATIENT ID NUMBER and PRESS #, DATE OF SERVICE and PRESS # (Receive Message)
3. Enter "2" if no more inquiries and to end call, OR,

Enter "1" for additional inquiries and repeat 2 above using PATIENT ID and PRESS # and DATE OF SERVICE and PRESS #

To Repeat Information

1. Enter "*" to repeat current message
2. Enter "1" for Eligibility and Recipient Liability
3. Enter "2" for Coordinated Services Program and Primary Care Provider (PCP)
4. Enter "3" for Co-Payment
5. Enter "4" for Third Party Liability (TPL)
6. Enter "5" for Vision
7. Enter "6" for ALL Menu items
8. For Current Date, Press # Key, instead of 8 digit date