BlueCross BlueShield of New Mexico

TURQUOISECARE

Long Term Services & Supports

Blue Cross and Blue Shield of New Mexico • Provider Training • 2024

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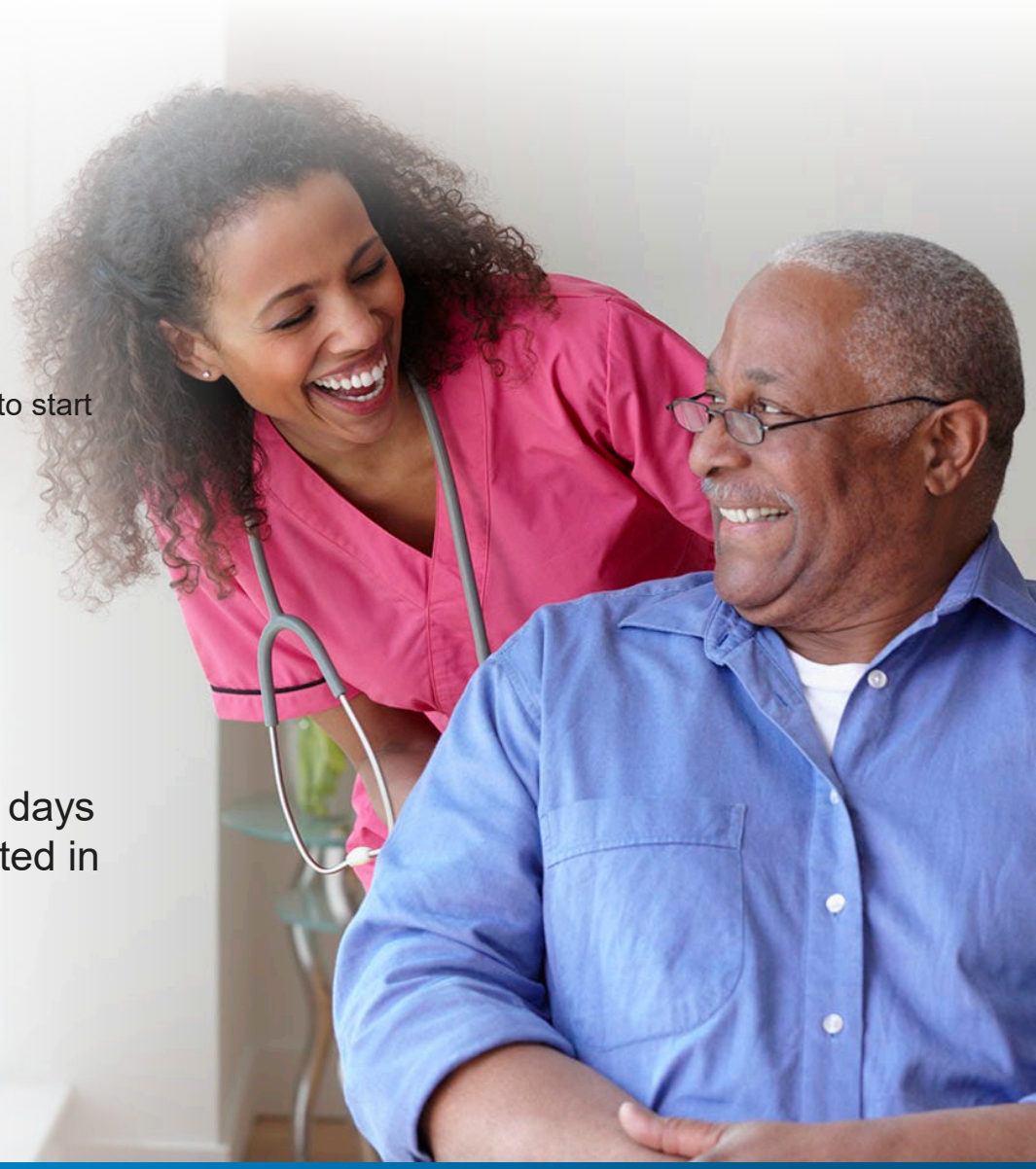
Nursing Facility (NF) Admissions and Discharges

Nursing facilities are required to notify Blue Cross and Blue Shield of New Mexico (BCBSNM) within 24 hours of a member's:

- Admission or request for admission including short-term stays
- Discharge:
  - Notify UM within 24 hours of the discharge
    - 30 days prior to planned a discharge
  - Facilities should notify their assigned Nursing Facility Care Coordinator as soon as possible to start the process of a safe reintegration
  - Has left Against Medical Advice
  - Hospital and/or Emergency Room encounters
  - Death
- Pending discharge
- Please call **877-232-5518**

Nursing Facility Level of Care (NFLOC) packets should be faxed within 30 days of admission and 60 days **prior** to current NFLOC expiration. If not submitted in a timely manner, it will affect the member's Medicaid eligibility.
Note: NFLOC should not be submitted for short-term stays.

- **Long Term Care (LTC):** 505-816-2093
- **Clinical documentation:** 505-816-3854



Important Reminders to Nursing Facilities

Initial Determinations

- All Services must be medically necessary
- Please refer to the Managed Care Policy Manual regarding procedures for prior approval

Redeterminations

- Medical documentation must be received by BCBSNM at least 60 calendar days prior to the start date of the new certification period for Low Nursing Facility (LNF) and 30 calendar days for High Nursing Facility (HNF)

Retroactive Medicaid Eligibility

- Written requests for prior approval based on resident's financial eligibility must be reviewed within 30 calendar days of the date of the eligibility determination

NFLOC Packet Components

Preadmission Screening and Resident Review

NFLOC Notification Form

- All requests for prior approval will be submitted on the NFLOC Notification Form
- Please document the type of review being requested at the top of the NFLOC Notification Form:
  - Initial
  - Continued Stay
  - Medicaid Pending
  - Transfer
  - Readmit
  - Reconsideration
- All other required fields must be completed

Procedure for Transfers Between Nursing Facilities

The receiving NF must notify BCBSNM by telephone that a transfer to its NF is to occur and the date of the transfer. Without this information, claims submitted by the receiving NF will not be paid.

- If there are **more than** 30 calendar days on the resident's current authorization, BCBSNM will fax the receiving NF the completed notification form which will include the prior authorization and date span.
- If there are **less than** 30 calendar days remaining on the current authorization, the receiving NF will request a continued stay on the notification form. BCBSNM will make a new NF LOC determination; the days remaining on the current certification will be added to the continued stay.
- Please write "TRANSFER" in the type of request box on the notification form.

The NF receiving the resident will obtain the status of resident's reserve bed days from BCBSNM through the notification form. This includes the number of days used during a calendar year and the reason for the use of these days. This information is placed in the resident's NF records.

NFLOC Packet Components (cont.)

Minimum Data Set (MDS)

- An MDS and other appropriate documentation must be completed for each resident for every situation requiring prior approval
- All locator fields must be clearly marked on the MDS
- When the resident goes from Medicare Co-Pay to Medicaid, the NF submits an Internal MDS that begins the UR process
- Appropriate documentation must accompany the MDS including a valid order and must:
  - **be signed** by a physician, nurse practitioner, clinical nurse specialist or physician assistant;
  - **be dated**; and
  - **indicate the Level of Care (LOC)** – either high NF (HNF) or low NF (LNF)

Please refer to the **New Mexico Medicaid Nursing Facility (NF) Level of Care (LOC) Criteria and Instructions**.

Agency-Based Community Benefit (ABCB) Covered Services

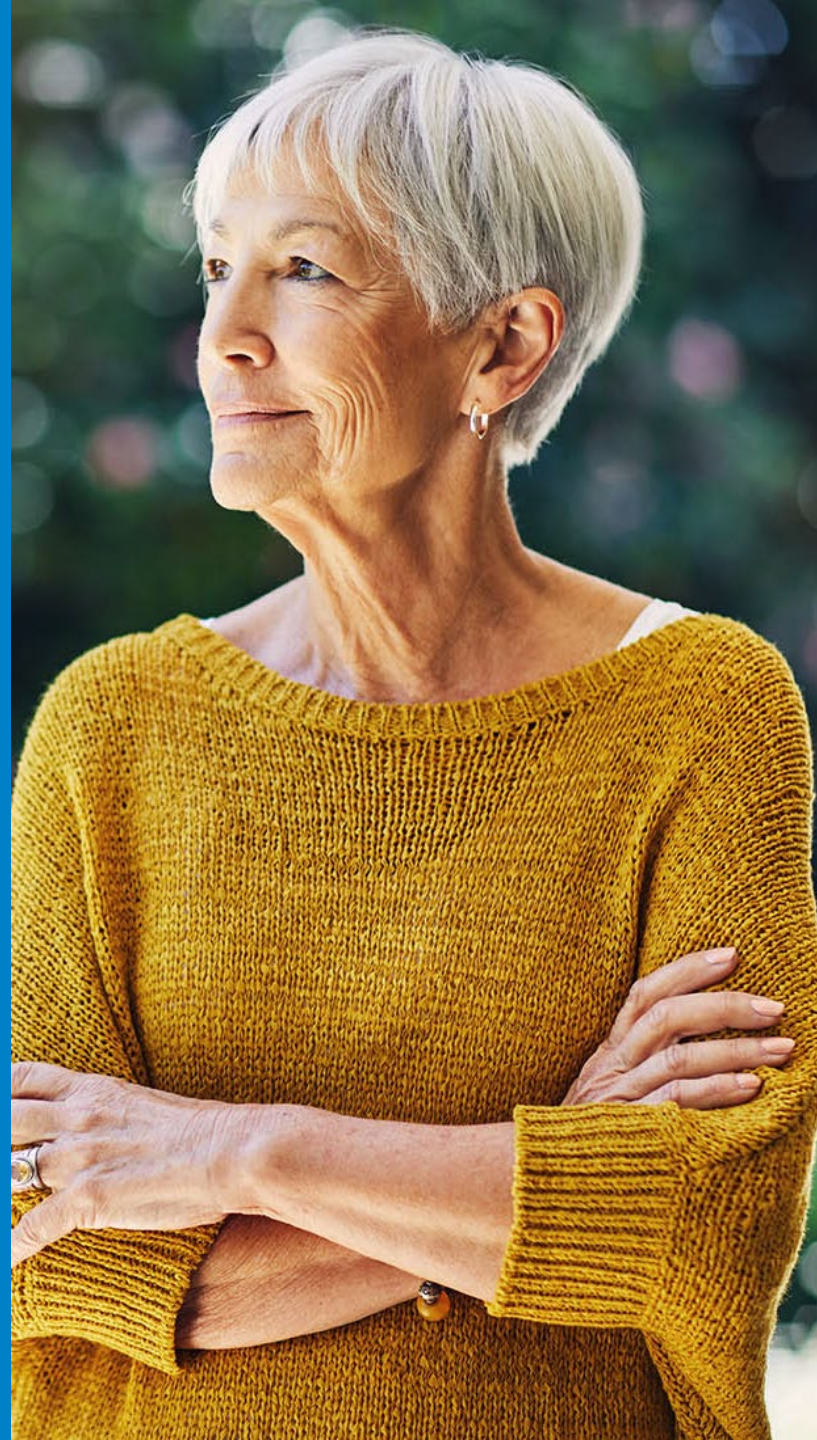
- Adult Day Health
- Assisted Living
- Behavior Support Consultation
- Community Transition Services
- Emergency Response
- Employment Supports
- Environmental Modifications
- Home Health Aide
- Nutritional Counseling
- Personal Care Services – Consumer Directed
- Personal Care Services – Consumer Delegated
- Private Duty Nursing for Adults
- Nursing Respite
- Respite (hourly and per diem)
- Skilled Maintenance Therapy Services
  - Occupational Therapy for Adults
  - Physical Therapy for Adults
  - Speech Therapy for Adults

Self-Directed Community Benefit (SDCB) Covered Services

- Behavior Support Consultation
- Customized Community Supports
- Emergency Response
- Employment Supports
- Environmental Modifications
- Home Health Aide
- Nutritional Counseling
- Private Duty Nursing
- Related Goods
- Respite
- Respite RN
- Self-Directed Personal Care
- Skilled Maintenance Therapy Services for Adults
- Specialized Therapies
- Start-up Goods
- Transportation (non-medical)

Self-Directed Community Benefit

SDCB Coverage Limitations	
Environmental Modifications	$6,000 every 5 years
Related Goods	$2,000 every year
Respite	300 hours per care plan year
Respite RN	300 hours per care plan year
Specialized Therapies	$2,000 per year
Start-up Goods	One-time coverage up to $2,000
Non-Medical Transportation	$1,000 per year



Home and Community-Based Services (HCBS) Settings Rule Overview

- The Centers for Medicare and Medicaid Services (CMS) issued a Final Rule for HCBS requirements on January 16, 2014 with an effective date of March 17, 2023
- Focused on improving available HCBS programs and overall quality
- Compliance with this Rule impacts state reimbursement from the Federal Government
- As a first step towards determining the compliance of New Mexico's HCBS provider settings, all selected Turquoise Care providers are required to complete an online survey

<u>Services impacted by the Final Rule Include:</u>

Employment Supports (non-residential service)

Adult Day Health (non-residential service)

Assisted Living (residential service)

HCBS Settings Rule Details

The Home and Community-Based settings must:

- Support individuals access to the greater community
- Provide opportunities for individuals to participate in individual and group outings (shopping, church, appointments)
- Provide the ability for individuals to seek employment
- Support individuals to receive the same degree of access to services in the community as those not living in a HCBS setting
- Allow individuals control over the scheduling of daily activities
- Allow visitors at any time approved by the individuals and access to private areas for conversation
- Must allow individuals to come and go as they please
- Provide access to transportation
- Compliance with all applicable rules and regulations.

HCBS Final Settings Rule Annual Attestation/Screening Tool and Audit

HCBS Providers will be required to complete an annual Attestation & Screening tool, along with an on-site audit completed by one of the Managed Care Organizations (MCO).

MCOs will train providers annually on the HCBS Final Settings Rule Requirements.

Providers will be required to complete an annual Attestation & Screening Tool.

MCOs will conduct annual on-site audits/screenings to initiate remediation process as applicable.

Care Coordination assessments and touchpoints will allow MCOs to gather valuable information on the HCBS Final Settings Rule Requirements.

Agency Based Community Benefit (ABCB) Annual Audits

MCOs will audit ABCB providers on an annual basis to determine compliance with the requirements set forth for all ABCB's as defined in the Turquoise Care Managed Care Policy Manual and the New Mexico Administrative Code (NMAC).

All elements of the audit are included under Section 8 of the Managed Care Policy Manual and Section 8.320.2.18.C NMAC.

This audit includes all ABCB Provider Types

Agency Based Community Benefit (ABCB) Annual Audits

Providers will receive a formal documentation request along with an audit tool with the details and a timeline to return the requested documents. Providers are to submit the requested documentation within fourteen (14) calendar days from the date of the letter.

Providers will receive a non-compliance letter if they fail to comply with the audit request. The goal is to help providers come into compliance.

Upon completion of the audit, providers will receive a Final Results letter which will score providers as "compliant" or "non-compliant".

Important Reminders to HCBS Providers

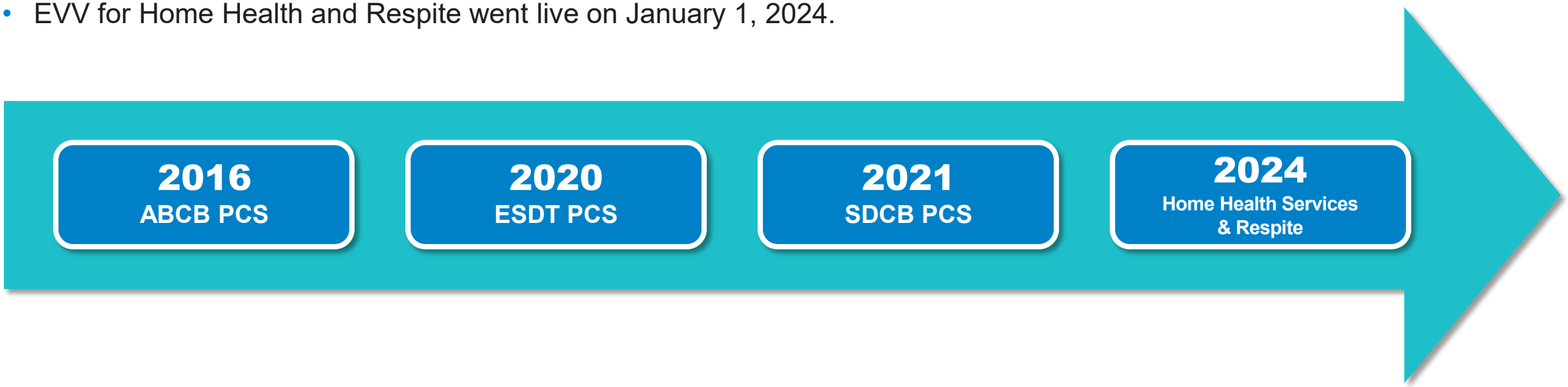
Information you provide helps BCBSNM and other providers to better serve members. Please remember to:

- **Complete and submit the Critical Incident Report when a member has an adverse event**
- **Assist members with contacting BCBSNM Member Services and/or their care coordinator when they move or change phone numbers**
- **Provide the Individualized Plan of Care when requested**
- **Notify the member's care coordinator if you become aware of any issues that may affect a member's health and safety**

Electronic Visit Verification (EVV)

EVV is a CMS mandate under the 21st Century Cures Act and established to improve access, quality of care, and health outcomes for Medicaid members who are receiving authorized personal care services (PCS), Home Health, and Respite.

- EVV for the Agency-Based Community Benefit population receiving PCS was implemented statewide in 2016.
- EVV implementation for Early and Periodic Screening, Diagnostic and Treatment – Personal Care Services (EPSDT PCS) on January 1, 2020
- EVV for the Self-Directed Community Benefit population began on January 1, 2021.
- EVV for Home Health and Respite went live on January 1, 2024.



Additional Notes on EVV

Manually Entered Web Claims

In April 2018, a new enhancement deployed within the Authenticare system required the Managed Care Organizations to review all manually entered web claims. This enhancement requires Personal Care Service agencies to collect and maintain documentation for every manually entered transaction and use of an exception.

- **Providers are required to provide detailed notes on each manually entered web claim.** *If BCBSNM has any questions regarding a web-based claim, either the assigned BCBSNM EVV contact, or a provider relations representative will request you to supply supporting documentation further justifying the reason for the manual entry.*

Authenitcare User Guides and Trainings

When logged into the Authenticare system, the agency can find helpful resources under the Custom Links tab on the main screen. These include the Authenticare User Manual, Provider Documents and recorded trainings. Contact Authenticare.Support@fiserv.com for any system issues, concerns, access issues, or training requests.

MobexHealth (fka Mobility Exchange)

To place orders for tablets, agencies can access MobexHealth at www.orders.mobexhealth.com . For issues or concerns regarding a tablet, you may contact the helpline at 1 (949) 527-6356 or email at mobexhealthsupport@mobexhealth.com.

EVV Access Options

Multiple Authenticare® Access Options Available

- Option #1: Member's home phone/landline or cell phone – If allowed by the member, caregivers will use their member's home phone/landline or cell phone to call into the AuthentiCare Interactive Voice Response (IVR) system; or
- Option #2: Caregiver's Mobile Device (smartphone or tablet) with Stipend – Each managed care organization (MCO) will provide a stipend to the provider agency to create an incentive for caregivers to utilize their personal mobile device (smartphone or tablet) and existing data plan when using the AuthentiCare mobile application for data transfer. The entire stipend must be paid to the caregiver and the agency may not retain any of it. All stipend payments made by the MCOs are inclusive of gross receipts tax (GRT); or
- Option #3: Tablets – The option to order a BCBSNM-owned WiFi-enabled tablet for those caregivers who do not have access to a personal mobile device (smartphone or tablet) or a member's home phone/landline or cell phone. Provider agencies can place orders through www.orders.mobexhealth.com. Please ensure all orders include a valid BCBSNM member subscriber number or New Mexico Medicaid ID.

Managed Care Policy Manual

The purpose for the Managed Care Policy Manual (the Manual) is to provide a reference for the policies established by the New Mexico Health Care Authority (HCA) for the administration of the Medicaid managed care program and to provide direction to the managed care organizations (MCOs) and other entities providing services under managed care.

This Manual should be used as a reference and a general guide. It is a resource for interpreting the Medicaid Managed Care Services Agreement (the Agreement) and New Mexico Administrative Code (NMAC) rules pertaining to managed care.

- ✓ Section 6: Nursing Facilities (NF)
- ✓ Section 7: Community Benefits
- ✓ Section 8 : Agency Based Community Benefits (ABCB)
- ✓ Section 9 : Self Directed Community Benefits (SDCB)

New Mexico Administrative Code (NMAC)

The New Mexico Administrative Code (NMAC) is the official collection of current rules (regulations) written and filed by state agencies to clarify and interpret laws passed by the legislature.

Helpful Sections for Providers:

Chapter 302 – Medicaid General

Chapter 308 – Managed Care Program

- NMAC 8.308.12 Community Benefits

Chapter 312 – Long Term Care Services / Nursing Services

Chapter 320 – Early and Periodic Screening, Diagnosis & Treatment Services (EPSDT)

BCBSNM LTC Key Contacts

BCBSNM **Long Term Care Network Representatives** are organized by geographical region.

- For the most up to date list of LTC Provider Representative assignments, please visit https://www.bcbsnm.com/provider/contact-us

TBD
Northwest Region
Southwest Region Alpha N-Z
Bernalillo County Alpha F-R

TBD
Eastern Region
Southwest Region Alpha A-M
Bernalillo County Alpha A-E and S-Z
Value Based Providers (LTC)

Electronic Visit Verification
EVVBCBS@bcbsnm.com
Office: 505-816-2237

Authorizations
PCS@bcbsnm.com

Reoccurring Meetings/Trainings

BCBSNM holds regular provider meetings which allows providers to collaborate with BCBSNM and identify trends and issues that need resolution. It also allows providers an opportunity to request specialized trainings.

Some of these meetings are in partnership with the other MCOs and/or HCA.

- Personal Care Service (PCS) Provider Meetings
- Assisted Living Facility (ALF) Provider Meetings
- Nursing Facility (NF) Provider Meetings

If you are interested in attending or need to update your agency's contact information, please reach out to your assigned provider representative.