D·B·H·D·D

Georgia Department
of Behavioral Health
& Developmental
Disabilities

BE D·B·H·D·D
BE COMPASSIONATE
BE PREPARED
BE RESPECTFUL
BE PROFESSIONAL
BE CARING
BE EXCEPTIONAL
BE INSPIRED
BE ENGAGED
BE ACCOUNTABLE
BE INFORMED
BE FLEXIBLE
BE HOPEFUL
BE CONNECTED
BE D·B·H·D·D

Welcome to the Quarterly DBHDD All-State Provider Meeting!

Todays Agenda…

Topic	Time	Presenter
Opening Welcome and Updates	9:00 am- 9:10 am	Ronald Wakefield, Division Director IDD, DBHDD
EVV- Updates and EVV Q/A	9:10 am- 9: 45 am	Brian Dowd, Deputy Executive Director Policy, Compliance and Operations Office Medical Assistance Plans, DCH
Statewide Transition Plan – Updates and STP Q/A	9:45 am- 10:15 am	Rebecca Dugger, Deputy Executive Director, Eligibility and Enrollment Division of Medicaid, DCH
5% Payment Rate Increase- Updates CRA- PA Clarification	10:15 am- 10:45 am	Ron Singleton, IDD Budget Manager, DHBDD
IDD-Connect Updates Multifactor Authentication	10:45 am- 11:00 am	Sheyla Duvilaire, IDD Director/Program Manager, The Georgia Collaborative ASO
Accessing IDD-Connect Reports	11:00 am- 11:15 am	John Quesenberry, Director of Information Management and Reporting, DBHDD
Office of Health and Wellness (OHW) Updates	11:15 am- 11:30 am	Dana Scott, Director of the Office of Health and Wellness & Karen Cawthon, OHW Project Manager, DBHDD
Rate Study Updates NOW/COMP Waiver Updates	11:30 am- 11:45 am	Ashleigh Caseman, Director of Waiver Services, DBHDD
NOW and COMP Quality Review Tool Changes	11:45 am- 12:00 pm	Nancy Overs-Ikard, MBA IDD Director of Quality, The Georgia Collaborative ASO
Crisis Stabilization and Diagnostic Center (CSDC)	12:00 pm- 12:10 pm	Beth Shaw, Director of the Office of Crisis and Transition Services, DBHDD Mercedes Brown, I/DD Crisis Stabilization Services Manager, DBHDD
Question and Answers	12:10 pm- 12:30 pm	All

Opening Welcome & Updates from Ron Wakefield, Division Director IDD, DBHDD

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Department of Community Health
Electronic Visit Verification (EVV)

NOW/COMP Provider Meeting
Status Update

Electronic Visit Verification

- General EVV Program Updates
- Operations Status Updates
- Conduent | Netsmart Updates
- Supporting Orgs Updates
- HHCS Implementation Updates
- Next Quarter Focus

Electronic Visit Verification

Program Updates

- CMS Certification
- Current Billing Exceptions
- Third-Party Integrations
- Common Issues & FAQs

General Program Updates

CMS Certification

On February 9th, 2022, Georgia's EVV solution was granted the Centers for Medicare and Medicaid Services (CMS) certification approval. **The CMS certification is a huge achievement!**

CMS aims to ensure that systems receiving federal financial participation (FFP) are meeting the needs of the states and of CMS. The certification of the EVV solution is structured around the following elements:

- Outcome statements
- Evaluation criteria and
- Key Performance Indicators (KPIs)

General Program Updates

Current Billing Exceptions

There is one (1) remaining exception to the January 1, 2022, EVV mandatory claims deadline. Providers that have claims that fall within the following exception are able to submit claims directly to GAMMIS until upgrades to the Netsmart solution are completed.

1. **A claim type tied to an open "Tier 2" or higher ticket with Netsmart.**

Only providers submitting claims that meet the above exception criteria may submit those claim types directly to GAMMIS. Providers submitting claims through GAMMIS without an open Tier 2 (or higher) ticket are subject to Corrective Action which may include denied claims payments or termination from the EVV Program.

The exceptions require manual claims intervention to override the edit for PSS / CLS providers. As a matter of process, these exceptions will deny when submitted directly to GAMMIS. Once the claim has been submitted to GAMMIS and denied, providers should submit the ICN for the associated denied claim. DCH will validate and match against the open ticket and manually override GAMMIS once all information is verified.

General Program Updates

Current Billing Exceptions

Georgia EVV Call Center:

Users can contact the Georgia EVV Call Center for technical issues or questions. They will need to provide the following information to create a support ticket:

- Agency Name
- Agency Medicaid ID
- Agency National Provider Identification (NPI) Number
- Agency Employee Identification Number (EIN) or Tax Identification Number (TIN)
- Contact Email Address
- Call Back Number

Primary: (833) 701-0012

Email: GAEVVSupport@Conduent.com

Website for Chat: https://www.gaevv.com/

Monday – Friday: 8:00AM – 7:00PM EST
Saturday/Sunday/Holidays: Closed

General Program Updates

Compliant Alternate EVV Vendors

Vendors compliant with the 21st Century Cures Act in Georgia (37 total)	
AlayaCare USA	GeoH Software
Alora Healthcare Systems	Home Care IT (eCaring)
Ankota	HomeNurse, Inc
Aveanna Healthcare	Information Age Technologies (Copilot Pro 21)
AxisCare	Kaleida Systems (eRSP)
Axxess	MatrixCare (Private Duty)
Billiyo Health	Maxim Healthcare
BrightSpring Health Services (formerly ResCare)	MedFlyt
BrightStar Care (ABS Mobile)	MedSide Healthcare
Carecenta	MEDsys
CareSmartz	MyEVV
CareTime	myEZcare
Caryfy	Netsmart (myUnity HER/Legacy EVV)
CellTrak Technologies	Rosemark-Shoshana Technologies
ClearCare Online Solutions	SMARTcare
CubHub Systems/CellTrak	SwyftOps
Direct Care Innovations (DCI)	Therap Services
Generations Homecare Systems (Integrated Database Systems)	Treasures Docs
	Webauthor

General Program Updates

Common Issues & FAQS

Billing-related Issues:

Users are to use GAMMIS to monitor service unit usage. Some providers have not closely monitored their service usage and can run out of approved units before the end of a period. Providers are to review their claims to ensure the correct number of units are being billed. If a claim has already been paid and an error is noted, an adjustment may need to be made. Adjustments to “paid” or “partially paid” claims are made within the EVV solution. If a claim is denied, providers will need to create a new claim in the EVV solution with edits to address the denial reason code.

Mobile App Issues:

A cell phone may need to be calibrated if app users are having GPS issues. Also, as a reminder, caregivers and aides should be sure to check in and out whether or not they are connected to Wi-Fi with the mobile app.

General Program Updates

Common Issues & FAQS

Missing Members / Missing Prior Authorizations:

EVV receives members and Prior Authorizations (PA) directly from GAMMIS. EVV cannot add members that are not in GAMMIS with an updated PA and proper eligibility aid category. "QMB/SLMB/QI1" only members cannot be added to GAMMIS until they have a waiver or other full Medicaid aid category.

If providers have a missing member or a needed PA update, they are to contact the EVV Call Center for assistance. They must have the GAMMIS PA information available to provide to the Call Center representative when they contact the Call Center.

General Program Updates

Common Issues & FAQS

Unspecified ICD-10 Codes:

Many EVV claims are denying because there are some “Unspecified” ICD-10 codes that cannot be billed in GAMMIS. The driver for this is the identification of a sub classification “U”. Claims will deny for this unspecified diagnosis edit.

Netsmart’s database is aligned with CMS guidelines for reimbursable codes however the solution needs to align with the GAMMIS exceptions. DCH provided a listing of the unspecified diagnosis code exceptions to align the Netsmart solution accordingly.

	CDE_DIAG	DSC_25	IND_SUB_CLASS	DTE_EFFECTIVE	DTE_END
2	B999	UNSPECIFIED INFECTIOUS DISEASE	U	20111001	22991231
3	D2230	MELANOCYTIC NEVI OF UNSPECIFIED PART OF FACE	U	20111001	22991231
4	D4951	NEOPLASM OF UNSPECIFIED BEHAVIOR OF KIDNEY	U	20161001	22991231
5	D49519	NEOPLASM OF UNSPECIFIED BEHAVIOR OF UNSPECIFIED KIDNEY	U	20161001	22991231
6	D75839	THROMBOCYTOSIS, UNSPECIFIED	U	20211001	22991231
7	E083219	DIABETES WITH MILD NONP RTNOP WITH MACULAR EDEMA, UNSP	U	20161001	22991231
8	E083299	DIABETES WITH MILD NONP RTNOP WITHOUT MACULAR EDEMA, UNSP	U	20161001	22991231
9	E083319	DIABETES WITH MODERATE NONP RTNOP WITH MACULAR EDEMA, UNSP	U	20161001	22991231
10	E083399	DIAB WITH MODERATE NONP RTNOP WITHOUT MACUL			
11	E083419	DIABETES WITH SEVERE NONP RTNOP WITH MACULAR E			
12	E083499	DIABETES WITH SEVERE NONP RTNOP WITHOUT MACUL			
13	E083519	DIABETES WITH PROLIF DIABETIC RTNOP WITH MACULA			
14	E083529	DIAB WITH PROLIF DIABETIC RTNOP WITH TRCTN DTCH			
15	E083539	DIAB WITH PROLIF DIABETIC RTNOP WITH TRCTN DTCH			
16	E083549	DIABETES WITH PROLIF DIABETIC RTNOP WITH COMB DI			
17	E083559	DIABETES WITH STABLE PROLIF DIABETIC RETINOPATHY,			
18	E083599	DIAB WITH PROLIF DIABETIC RTNOP WITHOUT MACULAI			
19	E0837X9	DIAB WITH DIABETIC MACULAR EDEMA, RESOLVED FOL			
20	E093219	DRUG/CHEM DIAB WITH MILD NONP RTNOP WITH MAC			
21	E093299	DRUG/CHEM DIAB WITH MILD NONP RTNOP WITHOUT			

diagnosis_codes	icn	note	Gainwell Technologies Comment
M130	2022152004202	255 - Diagnosis code.	Claim Failed edit 4280 correctly because diagnosis M13.0 is unspecified.
D6489,I10,M0579,M069	2022152003104	255 - Diagnosis code.	Claim Failed edit 4283 correctly because diagnosis D64.89 is unspecified.
I10,M1990	2022152003669	255 - Diagnosis code.	Claim Failed edit 4281 correctly because diagnosis M19.90 is unspecified.
M069	2022151011305	255 - Diagnosis code.	Claim Failed edit 4280 correctly because diagnosis M06.09/M15.0 is unspecified.
I693	2022076046638	255 - Diagnosis code.	Claiim Failed 4301 because Header/Parent Diagnosis billed per DCH Policy
M069,I10,R55	2022076046353	255 - Diagnosis code.	Claim Failed edit 4280 correctly because diagnosis M06.9 is unspecified.
M159,I10,I509	2022077037025	255 - Diagnosis code.	Claim Failed edit 4280 correctly because diagnosis M15.9 is unspecified.
M130,G3189	2022076040372	255 - Diagnosis code.	Claim Failed edit 4280 correctly because diagnosis M13.0 is unspecified.
M1990	2022076040044	255 - Diagnosis code.	Claim Failed edit 4280 correctly because diagnosis M19.90 is unspecified.
M159,M810,J45909	2022076005158	255 - Diagnosis code.	Claim Failed edit 4280 correctly because diagnosis M15.9 is unspecified.

General Program Updates

Common Issues & FAQs - GAMMIS

DCH receives several EVV-related questions regarding basic GAMMIS functionality.

As a reminder, GAMMIS functionality includes:

- Remittance Advice (RA) review
- Claims status review – including denial of claims
- Voiding claims
- Adjusting claims
- Service Unit(s) or Prior Authorization Unit(s) review

Electronic Visit Verification

Operations Updates

- Provider Outreach
- Compliance Monitoring
- Interactive Voice Response (IVR)
- EVV Testing Updates
- MITA Status Updates

Operations Update

Provider Outreach & EVV Compliance Monitoring

Purpose of EVV Provider Outreach:

To contact providers to inquire about claims submitted via GAMMIS instead of Electronic Visit Verification (EVV).

In addition, remind providers that EVV is federally mandated and make inquiries regarding compliance; specifically, identify whether a Tier II or III ticket has been obtained, provide information regarding how to contact Conduent and Gainwell as well as how to access additional training when needed.

Providers are asked to keep us informed of any continuing or new problems.

Operations Update

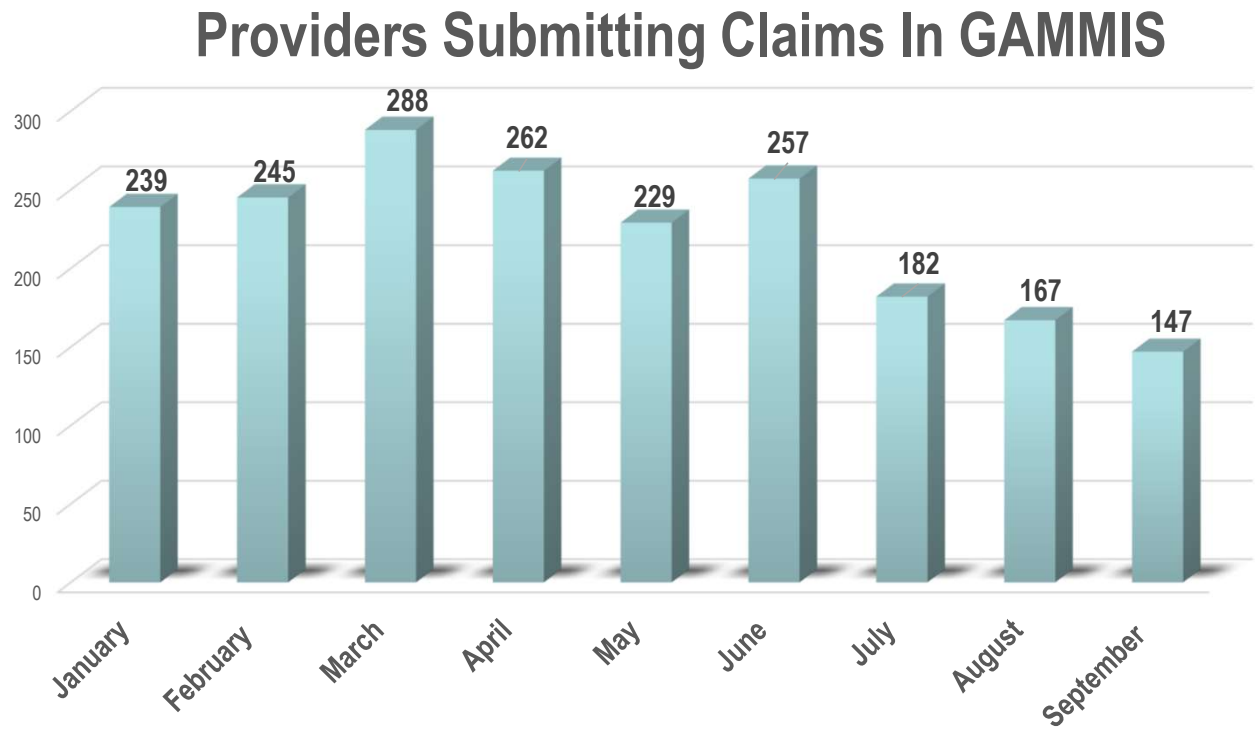
Provider Outreach & EVV Compliance Monitoring

EVV Compliance Monitoring includes:

- Monitoring the Weekly Pay and Report Data
- Tracking Common Billing Issues
- Issuing Corrective Action Plans

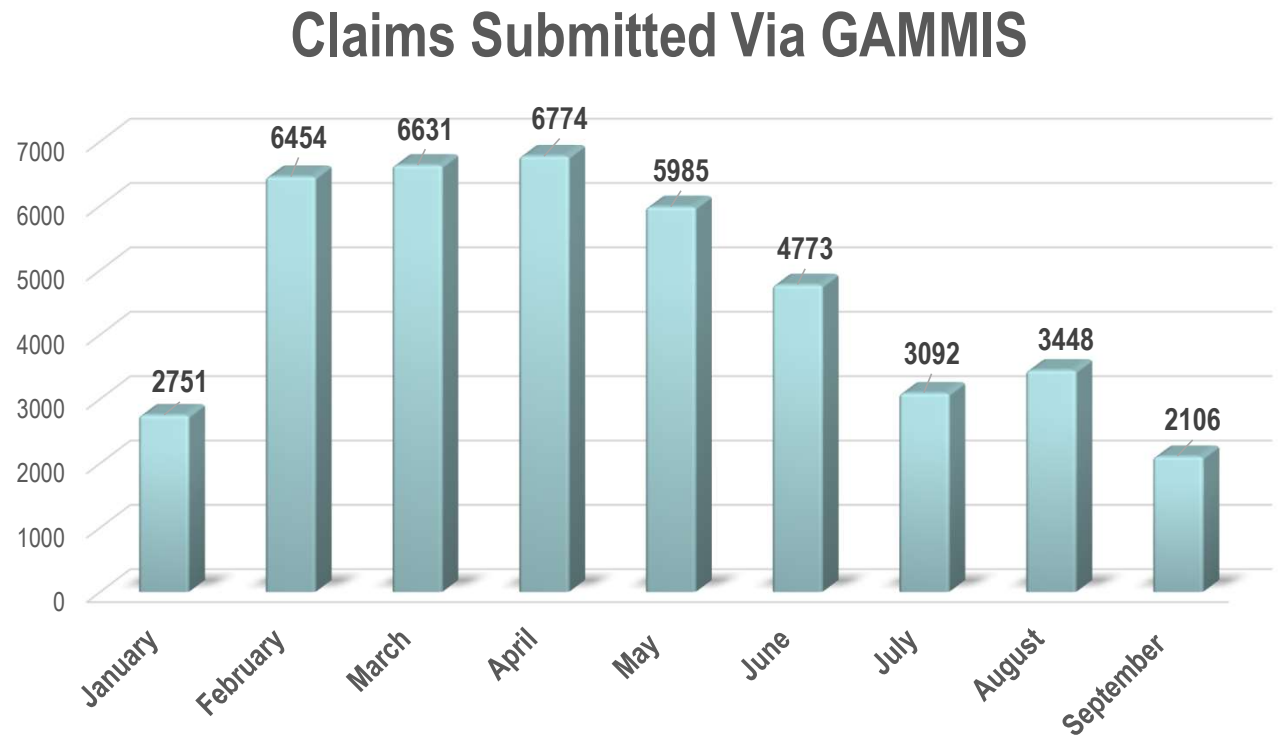
Operations Update

EVV Pay and Report Providers Submission (January – September 2022)



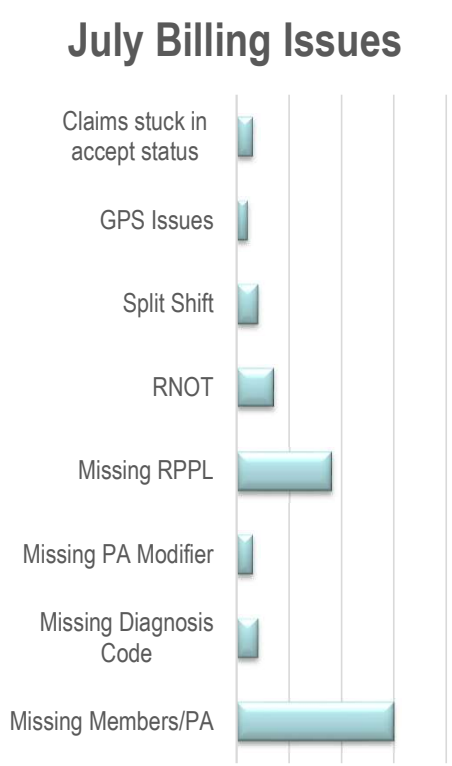
Operations Update

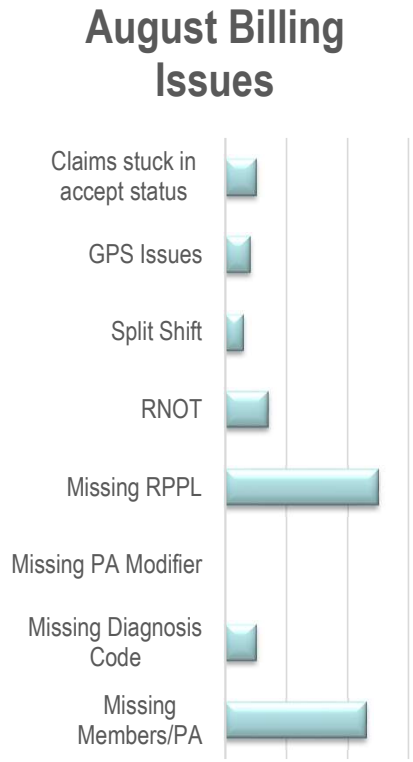
EVV Pay and Report Claims Submitted (January – September 2022)

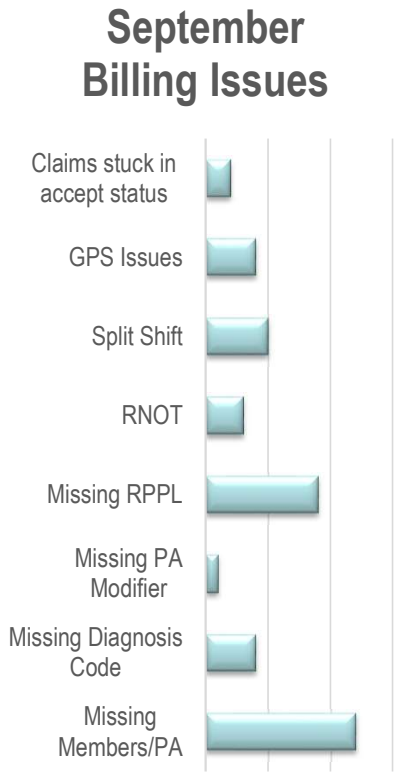


Operations Update

Common Billing Issues (July - September 2022)

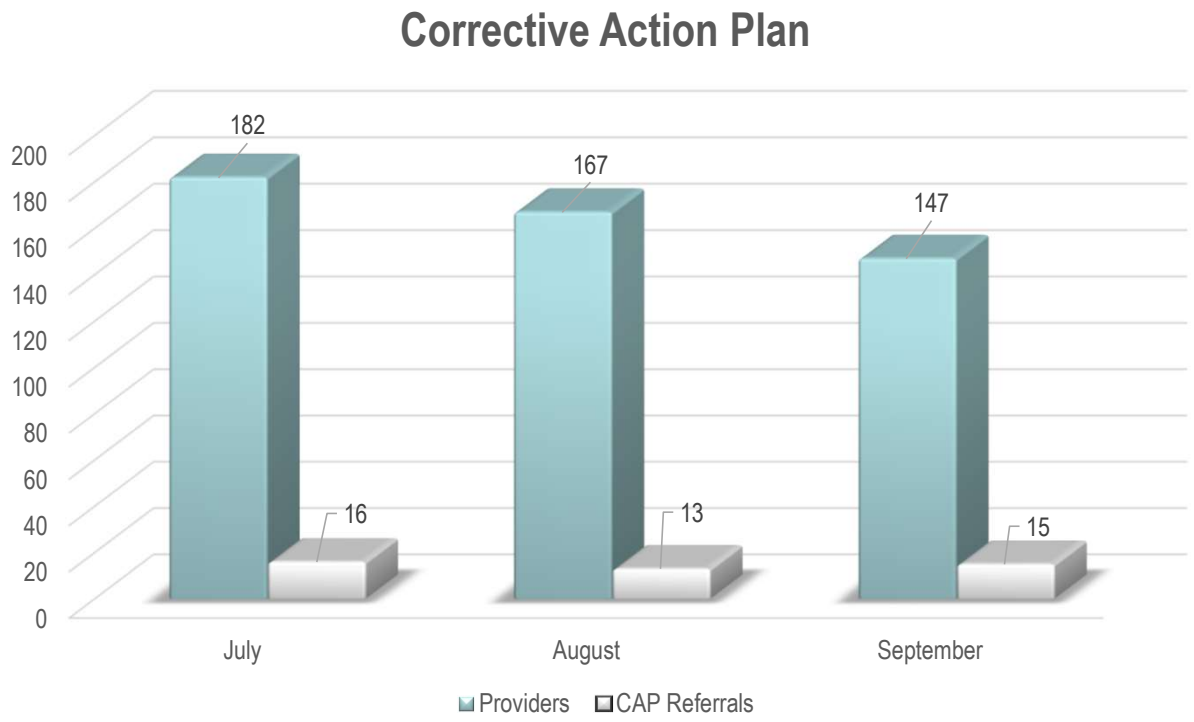






Operations Update

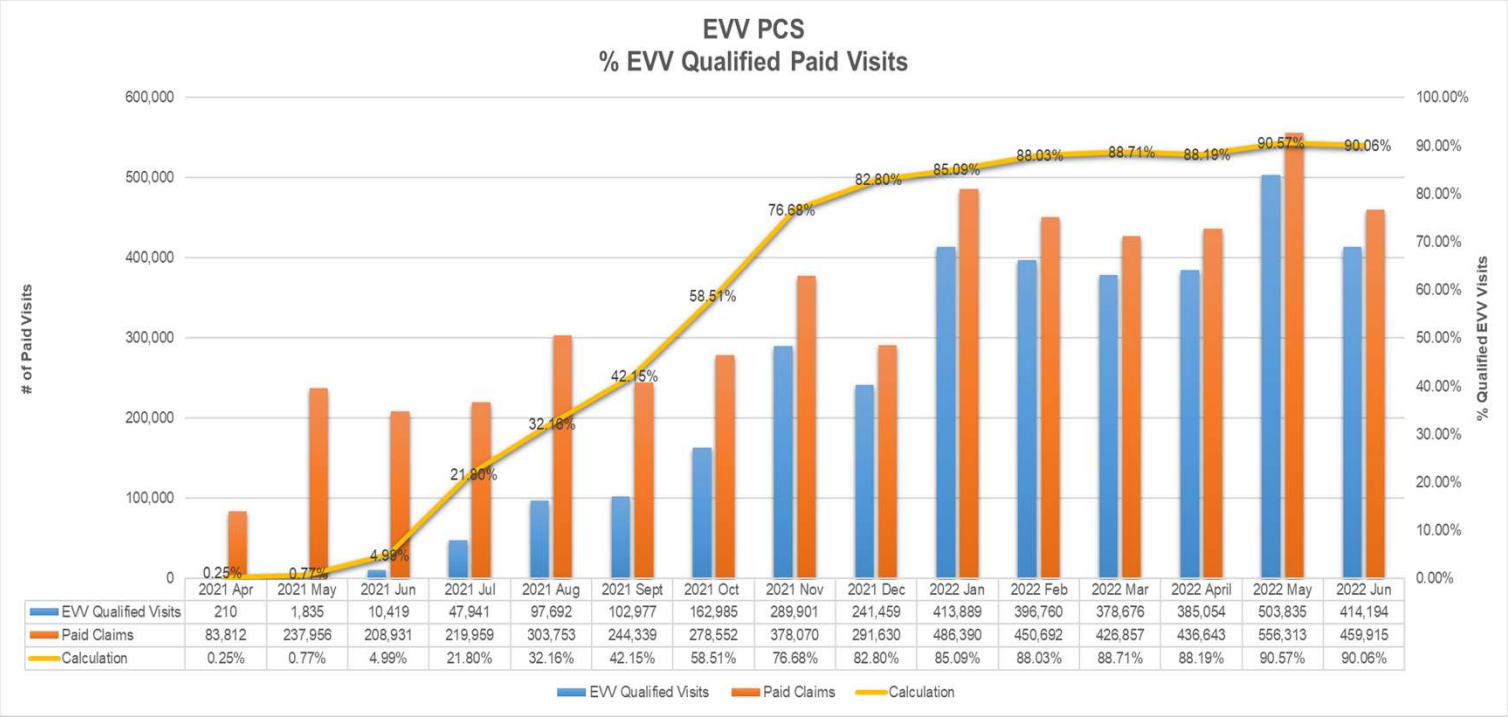
Corrective Action Plan (July - September 2022)



Operations Updates

MITA Status Updates

Matched Verified Visits to Paid Claims



	2021 Apr	2021 May	2021 Jun	2021 Jul	2021 Aug	2021 Sept	2021 Oct	2021 Nov	2021 Dec	2022 Jan	2022 Feb	2022 Mar	2022 April	2022 May	2022 Jun
EVV Qualified Visits	210	1,835	10,419	47,941	97,692	102,977	162,985	289,901	241,459	413,889	396,760	378,676	385,054	503,835	414,194
Paid Claims	83,812	237,956	208,931	219,959	303,753	244,339	278,552	378,070	291,630	486,390	450,692	426,857	436,643	556,313	459,915
Calculation	0.25%	0.77%	4.99%	21.80%	32.16%	42.15%	58.51%	76.68%	82.80%	85.09%	88.03%	88.71%	88.19%	90.57%	90.06%

Operations Update

Provider Outreach Resources

DCH EVV Email: EVV.Medicaid@dch.ga.gov

DCH EVV Website: https://medicaid.georgia.gov/programs/all-programs/georgia-electronic-visit-verification-evv/evv-service-providers

Conduent Call Center:

- **Phone: (833) 701-0012**
- **Email: GAEVVSUpport@Conduent.com**

Delicia Barber
Delicia.Barber@dch.ga.gov

Quiana Brimidge
Quiana.Brimidge@dch.ga.gov

Lynda W. Chapman, BS Pharm, MS Pharm, JD
Lynda.Chapman@dch.ga.gov

Operations Updates
Interactive Voice Response (IVR) Resources

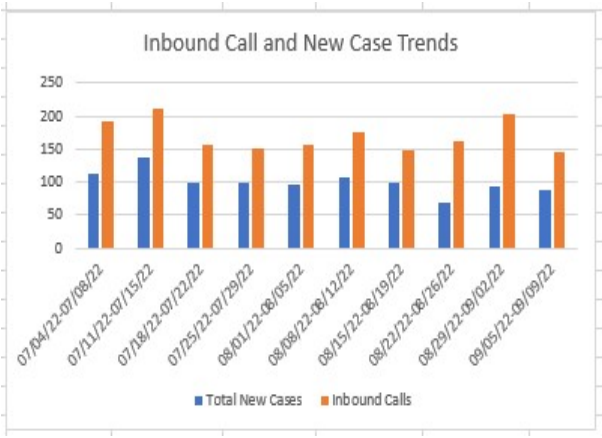
IVR Requests email:
evv.ivr_requests@dch.ga.gov

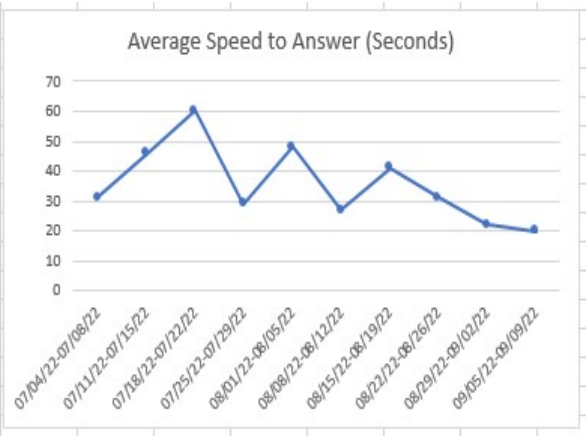
I'sha Williams
Isha.Williams@dch.ga.gov

Bryan Day
Bryan.Day@dch.ga.gov

Operational Status Updates and Metrics:

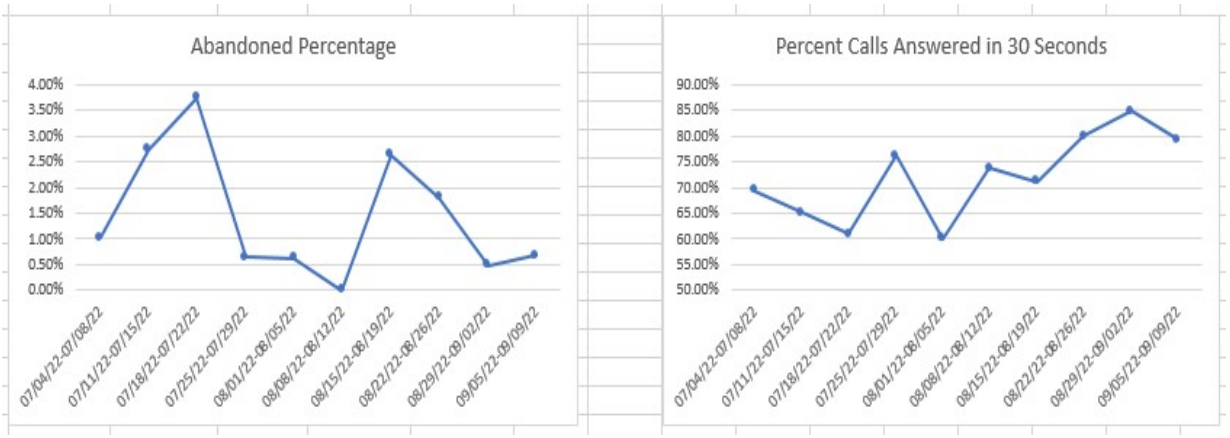
Call Center Operations (Q3 2022)





Operational Status Updates and Metrics:

Call Center Operations (Q3 2022)



Operational Status Updates and Metrics:

Call Center (L3 Ticket Type Overview)

- Top 3 Categories for the quarter:
- Missing member/Missing PA
  - Represented the largest category on most L3 reports
  - Continuous review of cases and escalate as needed
  - Time allowed for the files to come over/ensuring links etc.
- Missing RPPL and RNOT (rate not on file) rounded out top 3 for quarter

In September, the L3 count dropped drastically and no new categories trended for this quarter

Operational Status Updates and Metrics:

Provider Compliance Metrics (Adoption, Registrations and Trainings)

- Trainings
  - Mobile App Webinars had a 26% attendance rate
  - Admin Portal webinars had a 54% attendance rate
  - Claims Webinars had the largest attendance rate for the quarter with 50%

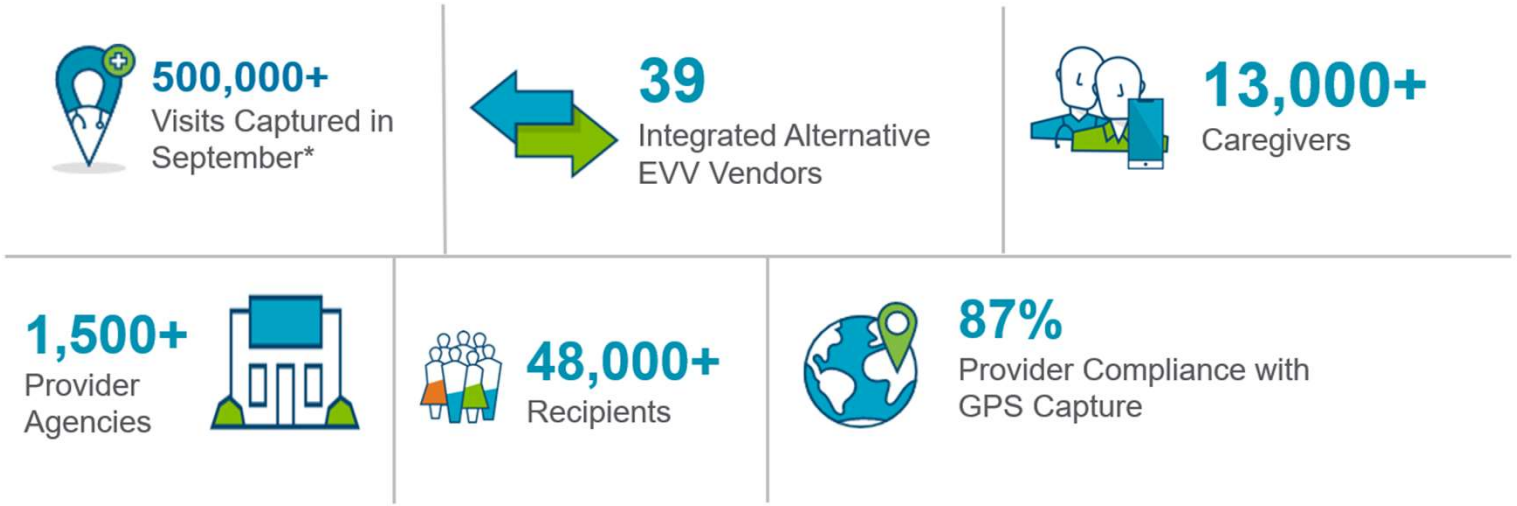
Risk & Issues

Unplanned Downtime:

- There was no EVV unplanned downtime for this quarter

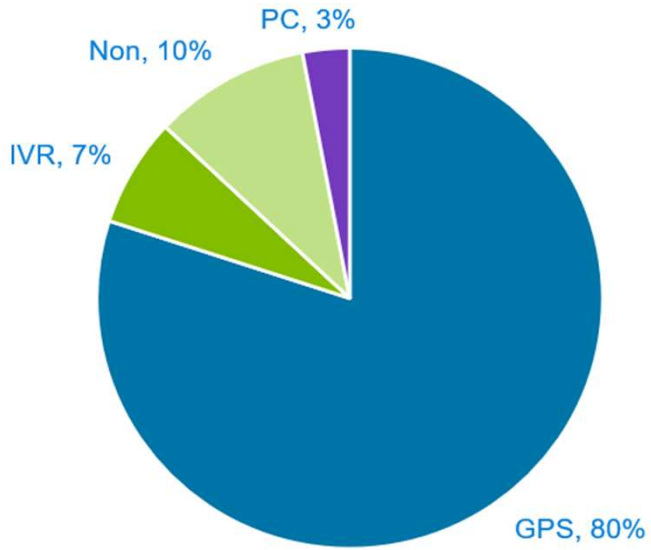
System Utilization & Performance

Netsmart EVV Platform Q3 2022



EVV Data Integrity

Paid Claims by Check-In Method – Q3 2022



6% from Q2 of GPS + IVR*

- GPS: Best practice – location was captured via an EVV solution
- IVR: Telephonic Check-In
- Non: Manual entry from non-Netsmart Solution. Completed with an EVV solution but location services were not available
- PC: Manual entry via computer on the Netsmart solution

Electronic Visit Verification

Home Health Care Service (HHCS) EVV Implementation

HHCS Implementation

Good Faith Effort (GFE) Exemption Request

The Congress-enacted 21st Century Cures Act requires states to implement EVV for Medicaid-financed Home Health Care Services (HHCS) by January 1, 2023, to avoid a reduction in federal Medicaid funding.

CMS began accepting Good Faith Effort (GFE) exemption requests in July for states who would like an extension to the implementation deadline to January 1, 2024.

Georgia submitted a GFE exemption request form on September 19th, 2022, and currently awaits CMS' response to the request.

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

HHCS Implementation

HHCS Implementation Milestones & Timeline

The EVV implementation for HHCS will consist of four phases:

- Registration Period
- Training Period
- Soft Launch Period, and
- Mandatory Go-Live by January 1, 2024 *(dependent upon GFE approval)*

More details regarding the milestones and timelines for the HHCS implementation are forthcoming. Please continue to check the EVV website or communications from DCH for updates!

Question and Answer (Q&A)

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Statewide Transition Plan
Ensuring Compliance

•Presented by: Rebecca Dugger, MHA, MA, ACPAR, APM, MCMP-II, SSBBP

Deputy Executive Director, Eligibility and Enrollment

Georgia Department of Community Health

Date: 02/6/2023

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Mission

The mission of the Department of Community Health is to provide access to affordable, quality health care to Georgians through effective planning, purchasing, and oversight.

We are dedicated to A Healthy Georgia.

Georgia Department of Community Health

Purpose

Shaping the future of A Healthy Georgia by improving access and ensuring quality to strengthen the communities we serve.

Georgia Department of Community Health

Outline

Settings Rule

Operations

HCBS Settings Rule

Important parts of the HCBS rule (CMS 2249F)

- Went into effect 3/17/2014 **(EIGHT YEARS)**
- Provides the definition and qualifications of a home and community-based setting under Medicaid (HCBS waivers and state plan)
  - Setting: Provider-owned or operated
- Defines person-centered planning requirements and conflict of interest standards for case management
- Must come into compliance by March 2023

Impacted Providers

Residential Settings

- Alternative Living Services
- Community Residential Alternatives

Non-Residential Settings

- Adult Day Health
- Community Access Group
- Pre-Vocational Services
- Supported Employment Group
- Out-of-Home Respite

What is the purpose of the *Settings Rule*?

The purpose of the *Rule* is to ensure that people who receive home and community-based waiver services have opportunities to access their community and receive services in the most integrated settings. The Rule stresses the importance of ensuring that individuals who rely on home and community-based services are not isolated or segregated and are able to exercise rights, optimize independence, and choose from an array of integrated service options and settings

What is it ????

- Ensuring that HCBS settings provide people with disabilities access to the broader community and facilitate relationships with people without disabilities (other than paid providers and staff).
- Ensuring that HCBS settings provide people with disabilities control over daily life decisions such as what to eat, when to go to sleep, and who can visit; with opportunities for competitive integrated employment; and with choices about what services they receive and who provides them.
- Assisting states with coming into compliance with the obligation under the Americans with Disabilities Act and the U.S. Supreme Court's decision in Olmstead v. L.C. to provide services in the most integrated setting.

HCBS Qualities and Characteristics

- It's about the **QUALITIES** of the setting
- Is the setting integrated in and supports access to the greater community?
- Does the setting provide opportunities to seek employment and work in competitive integrated settings, engage in community life, and control personal resources?
- Does it ensure that the individual receives services in the community **to the same degree of access as individuals not receiving** Medicaid home and community-based services?

HCBS Qualities and Characteristics

What HCBS is not:

- Nursing facility, IMD, ICF/DD, or hospital
- Settings in a publicly or privately-owned facility providing inpatient treatment
- Settings on grounds of, or adjacent to, a public institution
- Settings with the effect of **isolating** individuals from the broader community of individuals not receiving Medicaid HCBS

Setting Choice

Federal requirement

The person selects the setting from options including non-disability specific settings and private units in residential settings. The support coordinator identifies and documents setting options in the person-centered service plan. These options are based on the person's needs, preferences and, for residential settings, resources available for room and board

Member can make an informed choice of where they live, work, and receive services based on needs, preferences, financial resources and availability of settings, services and service providers. The support coordinator should give priority to the person's preferences, not the provider or guardian's preferences (unless for health and safety reasons).

Residential Settings

Federal requirement- 42 C.F.R. § 441.301 (c)(4)(vi)(A):

- The unit or dwelling is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities, and protections from eviction that tenants have under the landlord/tenant law of the State, county, city, or other designated entity. For settings in which landlord tenant laws do not apply, the State must ensure that a lease, residency agreement or other form of written agreement will be in place for each HCBS participant, and that the document provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law.

Provider Expectations

Lease, Residency Agreement or Individual Resident Placement Agreement should contain the HCBS-required resident rights and informs on the following:

- Amount and due date for rent or room/board
  - Person's responsibilities (i.e., maintaining his/her living space and not engaging in activities that disrupt or potentially cause harm to other residents)
  - Provider's timeframe for giving the person a notice of service termination and/or eviction
  - Conditions under which a provider could initiate an involuntarily termination the lease/agreement
  - Person's appeal rights information.

Provider Expectations

- The provider must give a signed copy of the lease/Residency Agreement to the member and maintain a copy of the agreement in the member's records. Case Management/Support Coordination should also have a copy of this agreement.

Provider Expectations

- Lease/Resident Agreements should be completed annually
  - Fees
  - Informed in writing at least 30 days of changes
  - Consent to release information
  - Continuous care plan development
  - Provision for transportation (access to emergency transportation at all times)
  - Refund policy (deceased, transfers, moves into institutional setting)
  - Copy of house rules must be in writing and posted in a conspicuous location

Providers Expectations

- The following should not occur:
  - A provider forces a person to move out without due process, including adequate notice
  - A provider discharges/evicts a person for an issue that was not included or described in the admission agreement that was signed by the person or his/her legal representative
  - A provider inappropriately uses a lease/Residency Agreement to force a person to waive/modify certain rights under “house rules” (e.g., a lease/Residency Agreement cannot prohibit a person from having any visitors).

Provider Expectations- House Operations

- Member should have lockable doors with key or fob
  - Staff knocks
  - Staff are trained on emergency measures when needed and door is locked
- Control over privacy
- Decorate their room
- Members have in/out ability even if the front door is locked (e.g., ring a bell, have their own key or request a key prior to leaving)
- Providers allow potential house members to meet housemates

When there is a medical issue or an identified health or safety concern, the provider needs to share their concern with the person's support coordinator. They must document the modification of rights in the person-centered plan.

Provider Expectations

People control their day-to-day lives in the same way other community members do. This includes control over when they like to wake up and get ready, as well as when and what they eat.

- To comply with this requirement, providers will ensure:
  - People have freedom to control their own schedule and activities (e.g., they do not have to adhere to a set schedule of waking, bathing, exercising or participating in activities)
  - Support activities are flexible and work around the person's preferred schedule
  - People do not have to follow one "set schedule" for all living in the setting
  - People have access to food (meals or snacks) and a place to store snacks (e.g., bedroom, kitchen), if desired
  - People have choices of when, where and with whom they would like to eat (e.g., no set "meal times" or assigned seats, a person can request alternative meals if desired, etc.)
  - People can eat a meal or snack at any time (e.g., if they miss a meal due to an activity, they do not have to wait for the next meal to eat; the provider can set aside a plate for them to reheat later or provide an alternate meal when they return)
  - People have the right to refuse to participate in activities the rest of the people in the setting want to experience.

Provider Expectations

- Members are supported in their day-to-day activities
- Providers are flexible when planning meetings and other activities so people can coordinate their schedules
- People can ask for assistance if they would like to schedule appointments for services in the community or arrange for transportation
- The provider creates an activity calendar each week so people can make decisions about activities in which they would like to participate
- People can help develop the week's grocery list for the week or activity options
- People are encouraged to share ideas and make choices about setting activities based on their own personal preferences and interests

Provider Expectations

The following should not occur

- The provider requires people to participate in activities
- The provider restricts a person's access to food because of the provider's personal belief that the food choice is not appropriate or healthy
- The provider only makes food available or accessible to people when the provider prepares regular meals or supplies a snack
- The provider places restrictions on whether a person eats dessert based on whether he/she finishes dinner
- The provider requires people to be awake and dressed at the same time as others
- The provider requires "lights out" or "bedtime" at a certain time.

Statewide Transition Plan-Residential Settings

VISITORS & COMMON AREAS

Provider Expectations – Visitors and Common Areas

- Members can have visitors of their choosing at any time
- No restrictions on visit times
- Right to privacy during the visit
- Provider cannot dictate who can visit
- Should refrain from scheduled visitation hours

To comply with this requirement, providers must ensure a person's physical environment meets his or her needs. For example, people must be able to use common areas in the home, such as the kitchen, dining area, laundry area and shared living space, to the extent they desire and safe to do so.

Control of Resources

Federal requirement

- The setting is integrated in and supports full access of people receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community to the same degree of access as people who do not receive Medicaid HCBS.

Provider expectations

- Provider expectations (if money management is a provider duty):
  - People have control over their personal funds and access to information about their income
  - The provider identifies roles and responsible parties as they relate to mo management
  - Staff are trained to safeguard funds and follow the person's plan with res funds, if such a plan is in place.

Rural settings and Integration

- **How can a rural setting meet this requirement?**

Integration is different in communities across Georgia. What can happen for a member in Atlanta will look very different in Crisp County. A very rural setting may have fewer opportunities for people to participate in community events or gatherings, but this is also true for the public in that rural community. The key is to be sure people have the same access to the community as others who live in that rural setting.

- **Is integration different for everyone?**

Yes, each person may have different needs and different desires. Providers are trained to address individual needs and desires and find a way to help every person meet those needs and desires to the greatest possible extent. Also, keep in mind that one person's needs should not limit another person's freedoms. For example, if one person cannot use revolving doors, the provider should not avoid group outings to places where there are revolving doors. This limitation of one person, limits everyone's options for community engagement.

No Coercion/ Restraint

Federal requirement

- For licensed residential facilities The Department of Community Health Healthcare Facility Regulation Division provides very clear statutory laws regarding a member's right to privacy, dignity and respect and freedom from coercion and restraint. Those guidelines can be found here:

Personal Care Homes-

- https://dch.georgia.gov/media/53121/download

No Coercion or Restraint

Types of Restraints not allowed

Physical	**Environmental**
Restraining limbs e.g., 4 persons to provide care Moving a person to another location against their will	Seclusion room Half doors, barricades Wander Guard Secure Units Removal of cane or walker
Mechanical	**Pharmacologic (when not prescribed)**
Limb, waist, and trunk Back-fastening seat belt Full bed-side rails Chair with locking table Broda/Geri	Antipsychotics Antidepressants Sedatives Benzodiazepines Over-the-Counter sleep aids

The following should not occur

- ☐ Staff gives people over-the-counter drugs to make people sleepy for the convenience of the provider.
- ☐ Staff posts sensitive member information on bulletin boards for other staff members to view for ease of communication.

Change of Ownership and other sticky topics

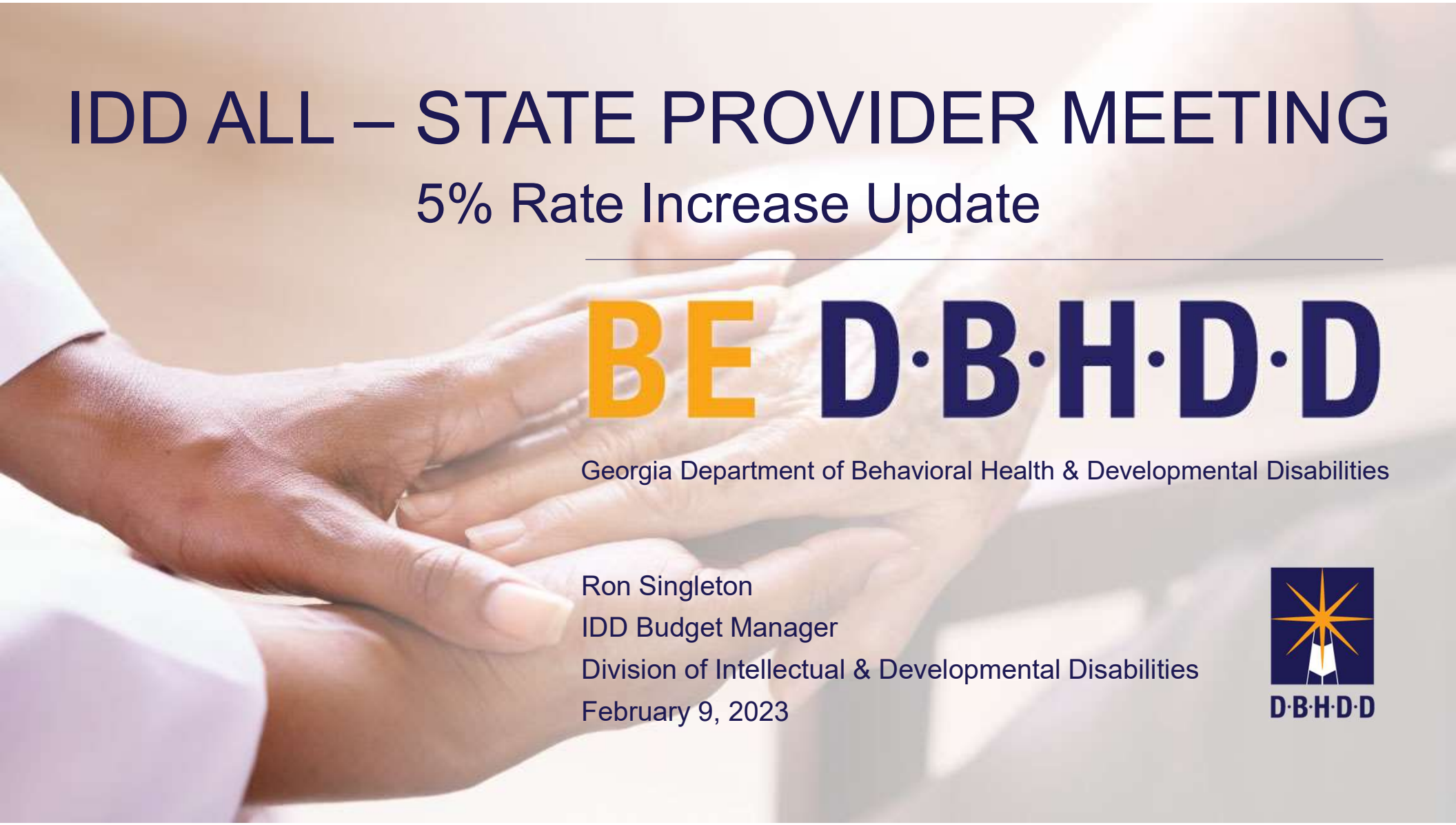
- If a CAG provider changes locations or adds another location, they should not engage in enticing or encouraging members to move to that location.

- At a minimum, a 30-Day notice is required if there is a provider change and Support Coordinator will work with the member to determine if they wish to remain with the new provider or broker to another provider.

Provider Reminders

Please ensure that you are attending

- Provider Trainings
- Townhalls if applicable
- Review Banner Messages
- Review Policy Manuals
- Refer to DBHDD and DCH Websites
- Social Media portals



IDD ALL – STATE PROVIDER MEETING

5% Rate Increase Update

BE D·B·H·D·D

Georgia Department of Behavioral Health & Developmental Disabilities

Ron Singleton
IDD Budget Manager
Division of Intellectual & Developmental Disabilities
February 9, 2023

D·B·H·D·D

5% Rate Increase Update

The Department of Community Health (DCH) and the Department of Behavioral Health and Developmental Disabilities (DBHDD) would like to provide the latest information regarding the reprocessing of paid NOW and COMP claims with dates of service beginning July 1, 2021, due to service the 5% rate increase.

More than $41,000,000 dollars in claims were reprocessed and paid over the last several weeks in four separate financial cycles. The dates of payments are as follows:

- **Financial Cycle #1 – Monday, November 21, 2022 (Paid Date)**
- **Financial Cycle #2 – Monday, December 5, 2022 (Paid Date)**
- **Financial Cycle #3 – Monday, December 12, 2022 (Paid Date)**
- **Financial Cycle #4 – Monday, December 19, 2022 (Paid Date)**

DCH and Gainwell did not provide a special Remittance Advice (RA) for the claims reprocessed during the cycles listed above.

5% Rate Increase Update

While reprocessing the nearly 2 million claims for the NOW and COMP waivers, it was discovered several claims that did not pay as expected. The reprocessing of these claims will result in a partial payment or a full recoupment of payments previously paid. Several examples include services such as Community Living Support Services in which the incorrect rate was billed on the original claim, as illustrated in the figures below.

Figure #1 displays and example of the 5% increased rate for Community Living Support Extended and Basic Services. The base rate (Appendix K) for the 'Extended' service was $6.31 per unit and with the 5% increase it was raised to $6.63. The same logic was used for the 'Basic' service.

Figure #1

Service Description	Procedure Code/Modifier	Appendix K Rate	5% Rate Increase	Difference
Community Living Support - Extended	T2025-U4	$6.31	$6.63	$0.32
Community Living Support - Basic	T2025-U5	$6.99	$7.34	$0.35

5% Rate Increase Update

Figure #2 displays an example where the provider billed the Community Living Support ***Extended*** Services procedure code but used the rate associated with Community Living Support ***Basic*** Services. The provider billed $6.99/unit but should have billed $6.63/unit, resulting in a recoupment of $0.36 per unit for claims that originally paid

Figure #2

		Incorrect Rate		
Service Description	**Procedure Code & Modifier**	**Rate Billed**	**5% Rate Increase**	**Difference**
Community Living Support - Extended	**T2025-U4**	**$6.99**	**$6.63**	**-$0.36**

This example is one of many that was encountered during the claims reprocessing. While there are some claims that may be addressed and paid appropriately in a follow-up review, there are those that will result in a full or partial recoupment of funds that were previously paid.

The final Financial Cycle for these claims will take place on 2/10/2023. If you have questions regarding a recoupment or partial payment, please contact Maya Carter at **mcarter@dch.ga.gov**.

5% Rate Increase Update: DBHDD & DCH Notifications

DCH Banner Message: Posted on February 3, 2023

Messages (2 rows returned)

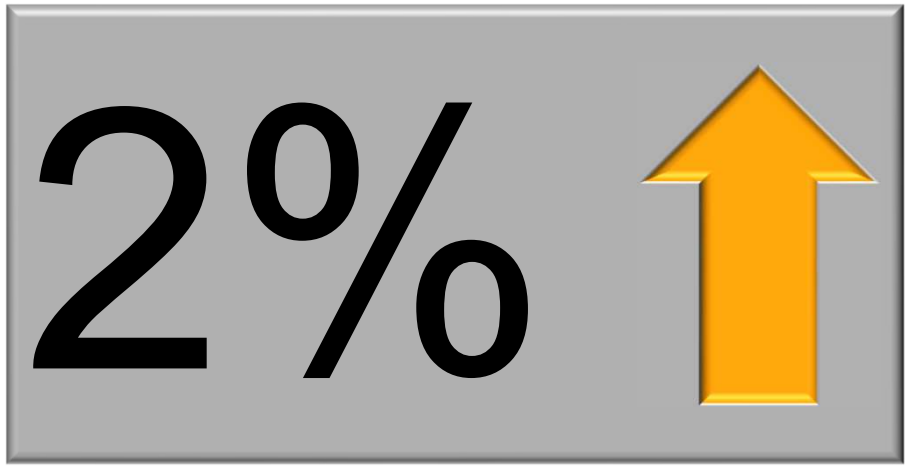
Type	Sent Date	Subject
ALL PROVIDER TYPES	02/03/2023	NOW/COMP Supplement K Mass Adjustment Update

https://www.mmis.georgia.gov/

DBHDD Special Bulletin: Posted on February 6, 2023

2% Rate Increase Update

The 2% provider rate increase from the FY23 Appropriations Bill [HB-911] is expected to be implemented for the NOW and COMP with IDD Connects in the coming months. There are no specific dates that are available at this time, but notifications will be provided as we get closer to the completion of this project.



The Impact of the Public Health Emergency (PHE)

In the February 2023 Networks News bulletin, it was noted that the National Public Health Emergency (PHE) is anticipated to end on May 11, 2023.

It was also noted that, *"the Appendix K allowances are aligned with the PHE and based on the current information noted above will expire on May 11, 2023. Importantly, the flexibilities and enhancements which are supported by the Appendix K for the NOW and COMP Medicaid Waiver programs* ***will remain in effect for up to 6 months after the end of PHE.****"*

Several of the allowances approved in the Appendix K were related to rate increases to specific services. The Appendix K approval on March 1, 2020, resulted in a rate increase for Support Coordination, Skilled LPN, and Fiscal Intermediary services. The Appendix K approval on March 1, 2021, continued the rate increase for these services and included a 10% rate increase for Community Access, Community Living Support, and Community Residential Alternative Services for 5 Person, 4 Person and 3 Person licensed settings. This included a 10% funding increase to Community Access and Community Living Support for Participant Directed services.

Amendments was done to the Appendix K to create a pathway to implement the 5% rate increase from the FY22 Appropriations Bill [HB-81] for all services (retro 7.1.2021) and the 2% rate increase from the FY23 Appropriations Bill [HB-911] for all services (retro 7.1.2022).

The Impact of the Public Health Emergency (PHE)

Services Impacted by the Appendix K Approval of March 1, 2020

Service Name	Base Rate	Effective March 1, 2020
Support Coordination	$152.88	$175.00

Service Name	Base Rate	Effective March 1, 2020
Nursing Services - LPN	$8.75	$10.00

Service Name	Base Rate	Effective March 1, 2020
Financial Support Services	$75.00	$95.00

The services above remained in effect by the Appendix K Approval of March 1, 2021.

The Impact of the Public Health Emergency (PHE)

Services Impacted by the Appendix K Approval of March 1, 2021 [10% Rate Increase]

Service Name	Base Rate	Effective March 1, 2021
Community Access Group	$3.10	$3.41
Community Access Individual	$7.41	$8.15

Service Name	Base Rate	Effective March 1, 2021
Community Living Support - Extended	$5.74	$6.31
Community Living Support - Basic	$6.35	$6.99
Community Living Support - 2 Member - Extended	$3.16	$3.48
Community Living Support - 2 Member - Basic	$3.49	$3.84
Community Living Support - 3 Member - Extended	$2.30	$2.53
Community Living Support - 3 Member - Basic	$2.54	$2.79
Community Living Support - Personal Assistance Retainer	$5.74	$6.31

The Impact of the Public Health Emergency (PHE)

Services Impacted by the Appendix K Approval of March 1, 2021 [10% Rate Increase]

Service Name	Base Rate	Effective March 1, 2021
Community Residential Alternative - Category 1 - 3 Person	$178.53	$196.38
Community Residential Alternative - Category 2 - 3 Person	$235.05	$258.56
Community Residential Alternative - Category 3 - 3 Person	$261.48	$287.63
Community Residential Alternative - Category 4 - 3 Person	$277.44	$305.18
Community Residential Alternative - Category 1 - 4 Person	$154.74	$170.21
Community Residential Alternative - Category 2 - 4 Person	$214.80	$236.28
Community Residential Alternative - Category 3 - 4 Person	$239.73	$263.70
Community Residential Alternative - Category 4 - 4 Person	$254.36	$279.80
Community Residential Alternative - 5 Person	$158.67	$174.54

The Impact of the Public Health Emergency (PHE)

Appendix K Service Rate Impact

		3/1/2021 - 11/11/2023	7/1/2021 - 6/30/2022	7/1/2022 - 11/11/2023
		Appendix K	Appendix K & Appropriations	
Service Name	Base Rate	March 2020 & March 2021	5% [FY22 HB-81]	2% [FY23 HB-911]
Support Coordination	$152.88	$175.00	$183.75	$187.43

		3/1/2021 - 11/11/2023	7/1/2021 - 6/30/2022	7/1/2022 - 11/11/2023
		Appendix K	Appendix K & Appropriations	
Service Name	Base Rate	March 2020 & March 2021	5% [FY22 HB-81]	2% [FY23 HB-911]
Nursing Services - LPN	$8.75	$10.00	$10.50	$10.71

		3/1/2021 - 11/11/2023	7/1/2021 - 6/30/2022	7/1/2022 - 11/11/2023
		Appendix K	Appendix K & Appropriations	
Service Name	Base Rate	March 2020 & March 2021	5% [FY22 HB-81]	2% [FY23 HB-911]
Financial Support Services	$75.00	$95.00	$99.75	$101.75

The Impact of the Public Health Emergency (PHE)

Post Appendix K Service Rate Impact, Effective 11/12/2023

		Effective 11/12/2023
		Appropriations
Service Name	Base Rate	5% [FY22 HB-81] + 2% [FY23 HB-911]
Support Coordination	$152.88	$163.73

		Effective 11/12/2023
		Appropriations
Service Name	Base Rate	5% [FY22 HB-81] + 2% [FY23 HB-911]
Nursing Services - LPN	$8.75	$9.37

		Effective 11/12/2023
		Appropriations
Service Name	Base Rate	5% [FY22 HB-81] + 2% [FY23 HB-911]
Financial Support Services	$75.00	$80.33

5% Increase: Troubleshooting for Billing & Claims

If you experience billing difficulties, please be sure to reach out to your Gainwell Representative for assistance. Information and guidance for contact information can be found at:

https://www.mmis.georgia.gov

For general questions about the recent rate increases, please contact the DBHDD Provider Issue Management System (PIMS) at:

Provider Issue Management System (PIMS)

IDD ALL – STATE PROVIDER MEETING

Community Residential Alternative Settings Overview

BE D·B·H·D·D

Georgia Department of Behavioral Health & Developmental Disabilities

Ron Singleton
IDD Budget Manager
Division of Intellectual & Developmental Disabilities
February 9, 2023

D·B·H·D·D

Community Residential Alternative

Policy

Community Residential Alternative - Policy

Comprehensive Supports Waiver Program (COMP)
Part III, Chapter 2300

Reimbursement Rates

- Chapter 2300, Section 2308
- Appendix A

Community Residential Alternative

Capacity (Group Homes)

Community Residential Alternative – Capacity (Group Homes)

Group Home rates are based on the licensed **Capacity** of the home rather than occupancy. Healthcare Facility Regulation (HFR), a division of the Department of Community Health (DCH), is responsible for licensing facilities in Georgia.
https://dch.georgia.gov/divisionsoffices/healthcare-facility-regulation

Licensed Group Home settings (2) are as follows (per waiver policy):

Community Living Arrangement (CLA)
- Provider-operated residence with license capacity approval of four or fewer residents.

Personal Care Home (PCH)
- Provider-operated residence with license capacity approval of four or fewer residents.

*DBHDD recognizes several Group Homes throughout the state that are licensed for five or more residents.

Community Residential Alternative – Capacity Verification

Licensed **Capacity** verification can be done using either of the two methods below:

1. Healthcare Facility Regulation's (HFR) Find a Facility website:
   - https://forms.dch.georgia.gov/HFRD/GaMap2Care.html

2. A copy of the provider's HFR license/permit

Community Residential Alternative – HFR Website

https://forms.dch.georgia.gov/HFRD/GaMap2Care.html



Name	Facility Type	Address	City	State	Zip	County	Bed Capacity	Telephone	Effective Date of License
	COMMUNITY LIVING ARRANGEMENT		MARTINEZ	GA	30907	COLUMBIA	4		08/19/2020
Name	Facility Type	Address	City	State	Zip	County	Bed Capacity	Telephone	Effective Date of License

Community Residential Alternative – HFR License/Permit

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

STATE OF GEORGIA

COMMUNITY LIVING ARRANGEMENT PERMIT

This is to certify that a permit is hereby granted to

[redacted] to maintain and operate a
(Name of Governing Body)

Community Living Arrangement named as [redacted] for 4 residents.
(Name of Residence) (number served)

Said residence and premises are located at [redacted]
(Street)

in MARTINEZ 30907 County of COLUMBIA , Georgia.
(City or Town) (Zip Code)

Permit effective date is Wednesday, August 19, 2020 and remains in effect unless revoked or suspended.

"This permit is granted pursuant to the authority vested in the Department of Community Health pursuant to O.C.G.A. Secs. 31-7-1 and 37-1-22 and signifies that its facilities and operations comply with the Rules and Regulations of the Department of Community Health on the date this permit was issued."

THIS PERMIT IS NOT TRANSFERABLE PERMIT NO. [redacted]

In Witness Whereof, we have hereunto set our hand this 25TH day of AUGUST , 2020

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

HEALTHCARE FACILITY REGULATION DIVISION

Melanie Simon

Melanie Simon, Division Chief

Community Residential Alternative – Current Rates (Group Homes)

Bed Capacity: 2 & 3

Capacity	Procedure Code	Rate
3 PERSON	T2033-U1-UP	$206.20
	T2033-U2-UP	$271.49
	T2033-U3-UP	$302.01
	T2033-U4-UP	$320.44

Bed Capacity: 4

Capacity	Procedure Code	Rate
4 PERSON	T2033-U1-UQ	$178.72
	T2033-U2-UQ	$248.09
	T2033-U3-UQ	$276.89
	T2033-U4-UQ	$293.79

Bed Capacity: 5+

Capacity	Procedure Code	Rate
5 PERSON	T2033-U5-UR	$183.27

Group Home rates are based on the licensed **Capacity** of the home rather than occupancy.

Community Residential Alternative – Group Home Rate Scenario

Bed Capacity: 5+

All three residents living in a Group Home licensed for 5 will all receive the rate associated with a **5 Person** home.

3 Residents

Rate per resident: $183.27

Community Residential Alternative

Host Home/Life Sharing Site

Community Residential Alternative – Host Home/Life Sharing

Host Home/Life Sharing site are not required to be licensed. Host Home/Life Sharing service rates are based on the category or tier of each resident. The overview of this process can be found the '**Assessment Levels Overview – Revised**' document on the DBHDD Residential and Respite Cost page located on this site: https://dbhdd.georgia.gov/residential-and-respite-cost-study.

Category	Procedure Code	Rate
CATEGORY 1	T2017-U1	$156.92
CATEGORY 2	T2017-U2	$194.51

Community Residential Alternative

Individual Service Plans & Prior Authorizations

Individual Service Plan Review Policy (Policy Stat)

The Service Planning Process and Individual Service Plan Development, 02-438

https://gadbhdd.policystat.com/policy/11222352/latest

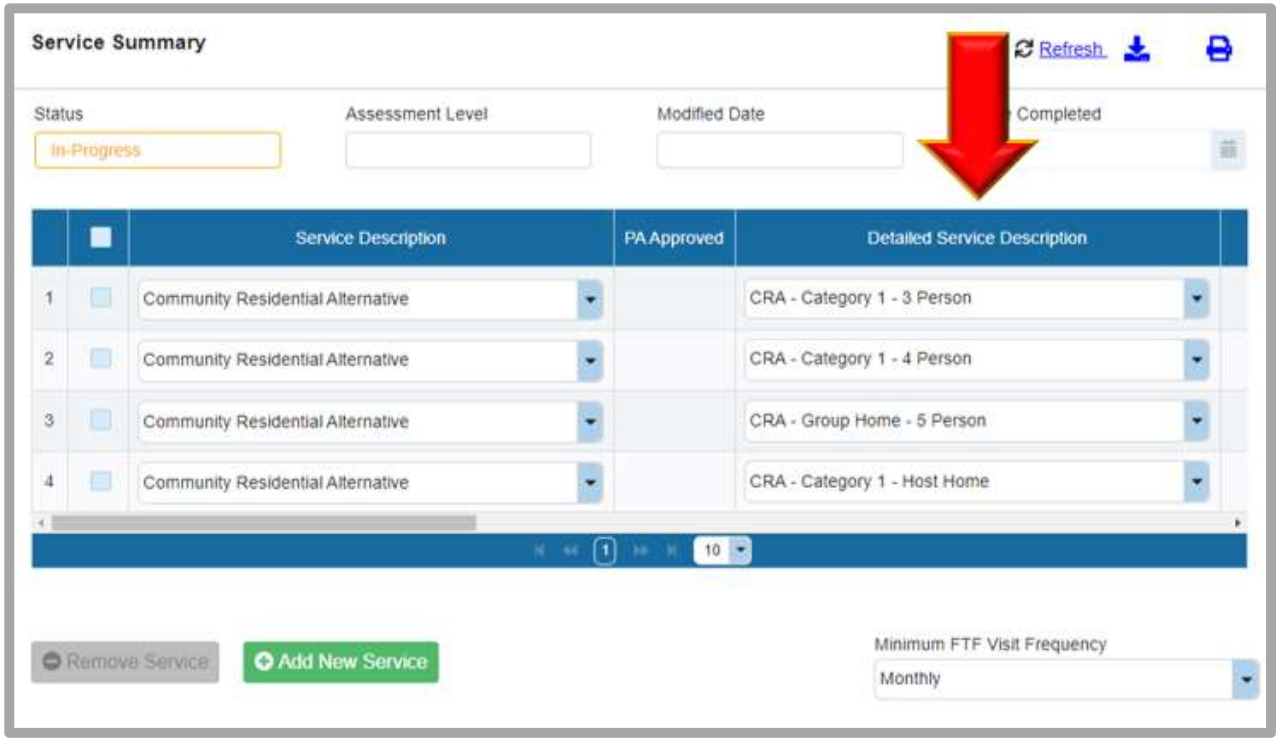
C. **Responsibilities of Each Team Member**

3. Responsibilities of other planning team members include the following tasks:

c. Service providers are required to review each annual ISP, within the online case management system, within five (5) business days following draft approval, and contact the SC or ISC with any concerns about service delivery,

Community Residential Alternative – ISP Service Summary

Please review the ‘Detailed Service Description’ to ensure the correct Group Home Capacity or Host Home/Life setting listed. This information will be captured on the prior authorization for billing.



Community Residential Alternative – PA Billing Scenario

The Medicaid system (GAMMIS) is updated to include Procedure Codes and Rates based on the licensed capacity of a setting or Host Home/Life Sharing approval.

PRIOR AUTHORIZATION SERVICE LINE					
Provider Name	**Provider ID**	**Procedure Code (Service)**	**Rate**	**Start Date**	**End Date**
Services "R" Us	111222333AA	**T2033-U3-UQ** (CRA - 4 PERSON)	$276.89	3/4/2022	3/3/2023

SERVICE: COMMUNITY RESIDENTIAL ALTERNATIVE - HOST HOME

Provider Rates - Procedure Pricing (111222333AA)

Proc Code [ ] **[Search]**

Procedure	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Rate	Rate Type	Effective Date	End Date
T2017	U1				$156.92	681 - COS 681	07/01/2021	12/31/2299
T2017	U2				$194.51	681 - COS 681	07/01/2021	12/31/2299

Claim Result: Suspended (NO PROVIDER RATE FOR DATE OF SERVICE - 2615)

Billing: Helpful Tips from Gainwell Technologies

Claim Status

Once a claim has been processed, its status could be:

- **Paid:** Some or all of the claim was reimbursable.
- **Denied:** No part of the claim was found to be reimbursable.
- **Suspended:** Further processing is needed. The final determination may be dependent upon further review or receipt of additional information.

Billing: Helpful Tips from Gainwell Technologies

Working Your Denied Claims

Claims Management Tips

Reviewing, correcting, and re-submitting denied claims is central to your **revenue management**.

- Assign dedicated staff person to denials if possible.
- Document receipt of denials, reasons for denied payment and deadline for resubmission.
- Always review denial reasons (read twice, act once.)
- Make corrections involving missing or inaccurate info.
- Review clinical reasons for denial (service, diagnosis, etc.) with treating provider.
- Make any corrections possible.
- Re-submit claims in a timely manner.

******Denials = revenue delay, revenue loss.******

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

gainwell

Gainwell Technology: Troubleshooting for Billing & Claims

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Provider Issue Management System (PIMS)

Questions

The Georgia Collaborative ASO | D·B·H·D·D

Multifactor Authentication

ProviderConnect

Sheyla Duvilaire, IDD Director/Program Manager GA ASO

February 9, 2023

What is Multifactor Authentication (MFA)?

Multifactor Authentication (MFA) is an authentication method that requires the users to provide two or more verifications factors to gain access to an application (ProviderConnect), online account, or a VPN.

Why is Multifactor Authentication (MFA) important?

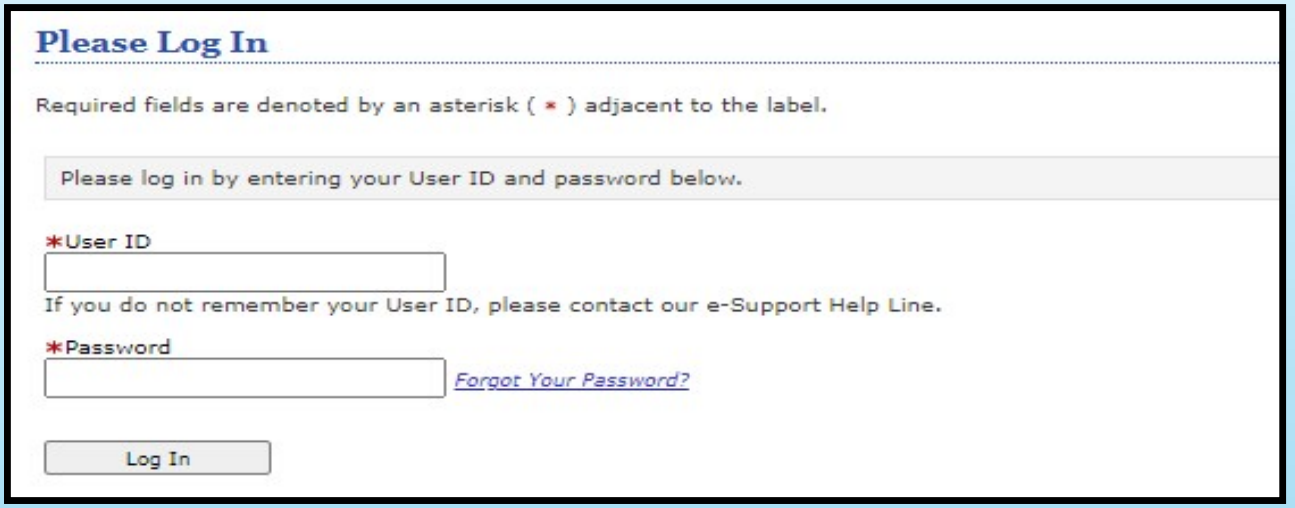
- MFA increases security because even if one credential (User ID and Password) is compromised, unauthorized users will be unable to meet the second authentication requirement, and will not be able to access the system.
- MFA can also reduce the risk of identity compromised by as much as 99.9% over passwords alone.

How does Multifactor Authentication (MFA) work?

- User download the required Authentication app to a mobile device (preferred option) or email from desktop/laptop (secondary option).
- Users log into ProviderConnect with their User ID and Password.
- User receives verification code received on mobile device or email.
- User enters verification code.
- Authentication completed.
- Home Page is displayed.

Current State Login – ProviderConnect

1. Log into ProviderConnect using User ID and Password
2. Home Page is displayed.
3. Nothing else is needed.

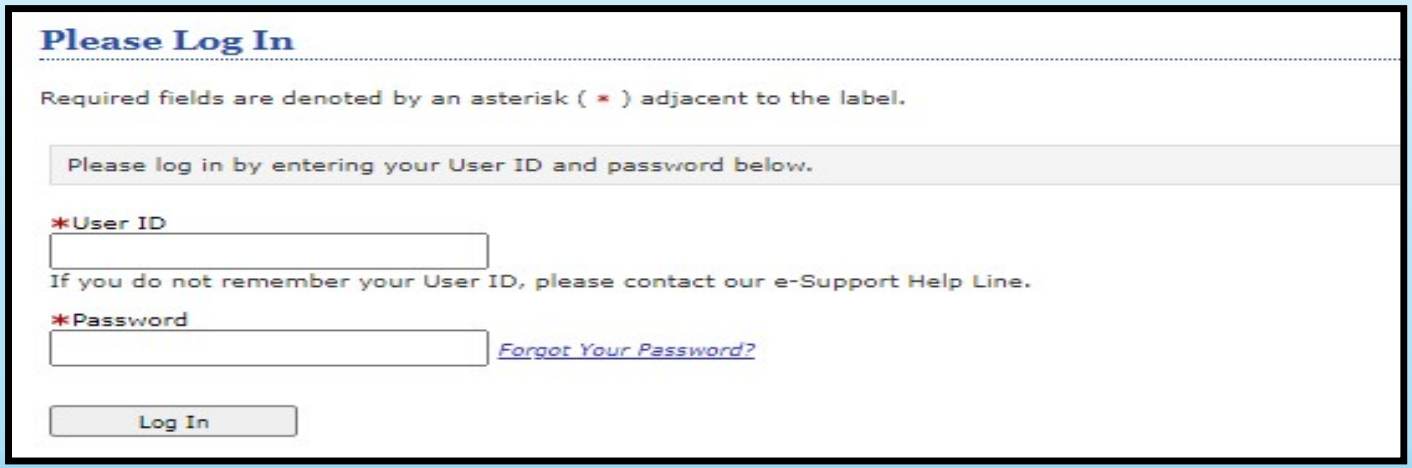


Future State Login - ProviderConnect and MFA

- The introduction of Multifactor Authentication requires ProviderConnect users to perform an additional step to log into the application.
- Two MFA choices:
  1. Mobile device using an Authenticator App, which is installed on their mobile device. (***Preferred option)***.
  2. Email based MFA authentication for users who do not have a mobile device (secondary option).

Future State Login – ProviderConnect and MFA

1. Log into ProviderConnect with User ID and Password.
2. Enter the verification code from your mobile device or email.
3. Home Page is displayed.
4. Nothing else is needed.



During MFA Grace Period

- A communication will be shared at a later date referencing the grace period, which will allow Providers to decide whether or not to set up their Multifactor Authentication during that time.
- Providers will enter their User ID and Password, and the information below is displayed:

After MFA Grace Period

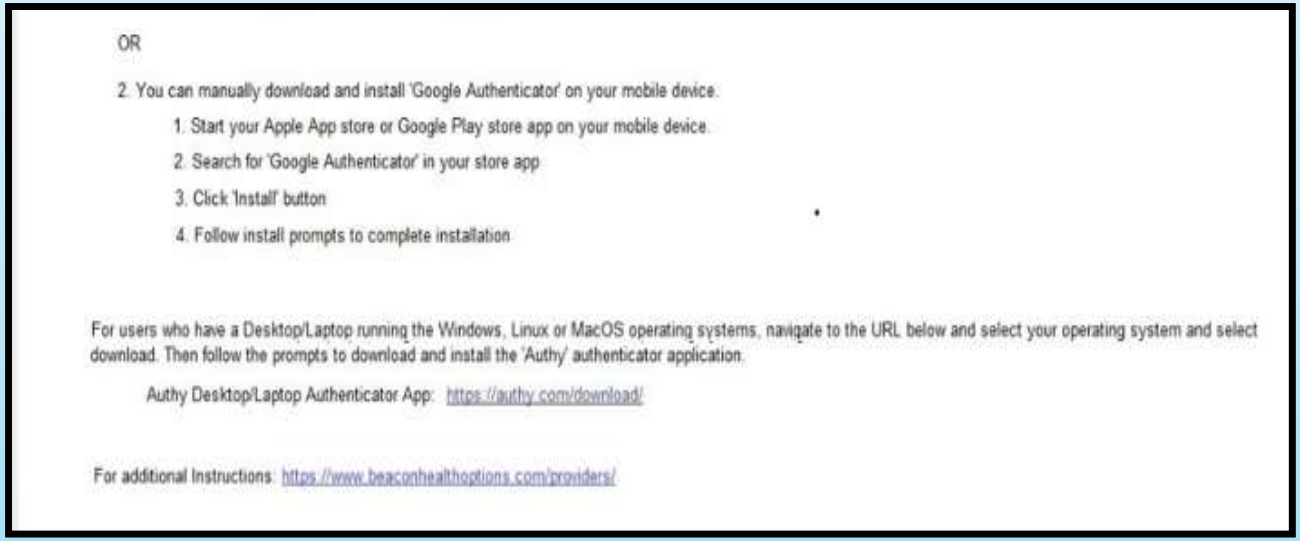
- After the grace period, the Provider will enter their User ID and Password, and the information below is displayed:

Step 1 – Install the Authenticator App using the QR Code

- Providers will set up Multifactor Authenticator app on their mobile device or computer using a QR code.

Step 1 – Manually install the Authenticator App (continued)

- Providers set up Multifactor Authenticator app on their mobile device or computer using manual download installation.



OR

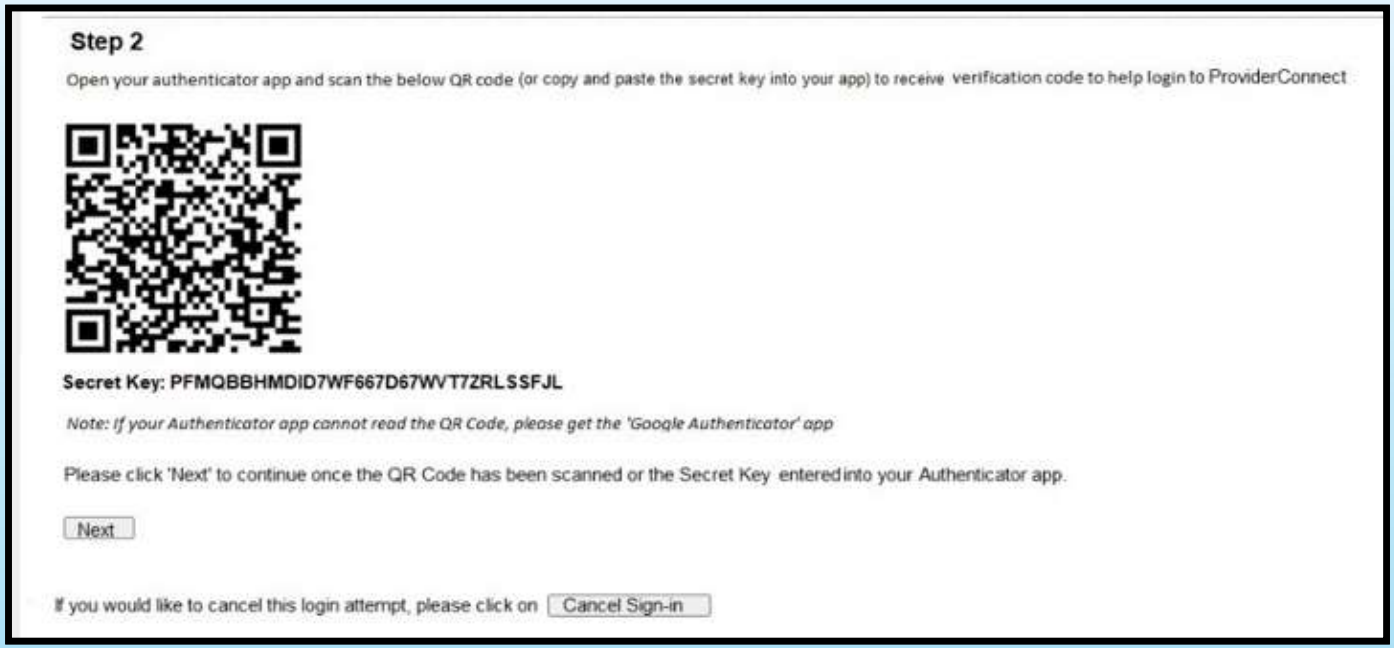
2. You can manually download and install 'Google Authenticator' on your mobile device.
    1. Start your Apple App store or Google Play store app on your mobile device.
    2. Search for 'Google Authenticator' in your store app
    3. Click 'Install' button
    4. Follow install prompts to complete installation

For users who have a Desktop/Laptop running the Windows, Linux or MacOS operating systems, navigate to the URL below and select your operating system and select download. Then follow the prompts to download and install the 'Authy' authenticator application.

Authy Desktop/Laptop Authenticator App: https://authy.com/download/

For additional Instructions: https://www.beaconhealthoptions.com/providers/

Step 2 – Open Authenticator App for Code



MFA – One-Time Password (OTP) Code Entry

- Providers enter the One-Time Password (OTP) code in the text box.

MFA – Invalid OTP Code

- If an invalid code is entered, Providers will see an error message, 'Invalid OTP code. Please try again'.

MFA – Email Entry

- Providers will receive an email with the OTP login code and enter the code in the text box.
- If the code is not received, the Provider can click 'Resend OTP' button to receive a new email.

MFA Resend OTP Email

- Providers will receive an email when 'Resend OTP' is clicked. A new code will be emailed to the user.

e-supportservices@carelon.com Dodd, Jacob

OTP from ProviderConnect zx

Security One-Time Password (OTP)

Thank you for requesting a verification code to login to your ProviderConnect account. Please note that this is a One-Time Password (OTP) and can only be used once. This OTP will only be valid for 10 minutes. To log in, enter the OTP on the 'One-Time Password (OTP) – Multifactor Authentication' screen and click 'Verify OTP'

One-Time Password: 649150

If you did not request this OTP, please contact e-Support Help Line at 888-247-9311 during business hours, Monday through Friday, 8 AM – 6 PM ET or you can email an Applications Support Specialist at e-supportservices@carelon.com

MFA – Email Entry Invalid OTP

- If an invalid code is entered, Providers will see an error message, 'Invalid OTP code. Please try again'.

Provider Session Times Out

- If the Provider session times out, the user will need to re-login.

MFA – Locked Account

- If the account has been locked due to invalid Multifactor Authentication attempts, please contact the e-Support Services at 1-888-247-9311, Monday through Friday 8 am – 6 pm ET to unlock your account.
- Once the account has been unlocked, the Provider will be able to log into ProviderConnect with their User ID and Password.

The Georgia Collaborative ASO | DBHDD

IDD REPORTS ACCESS

BE D·B·H·D·D

Georgia Department of Behavioral Health & Developmental Disabilities

John Quesenberry, Director
Office of Data & Information Management
February 9, 2023

D·B·H·D·D

How to Access IDD Reports

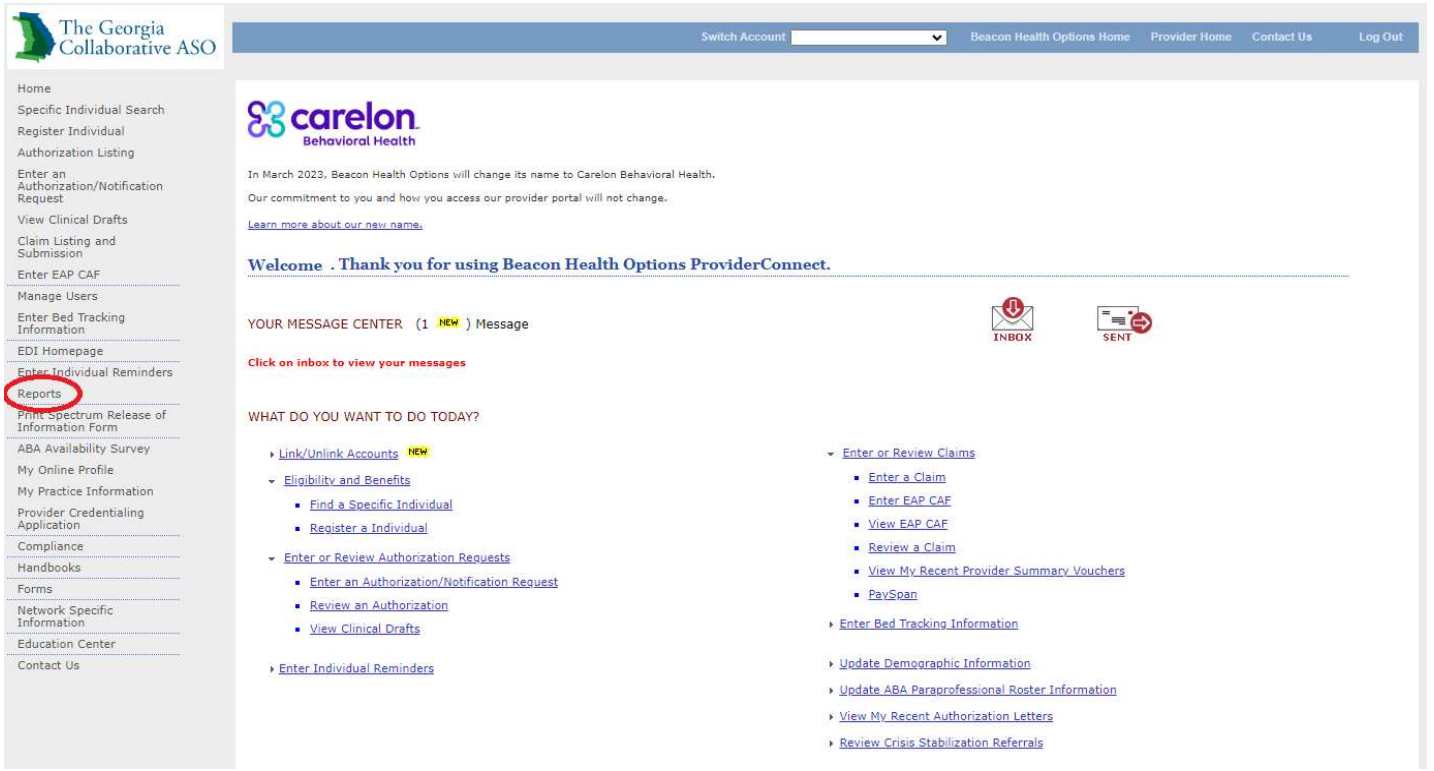
Providers will access IDD Reports via the Provider Connect Portal. (https://providerconnect.beaconhealthoptions.com/pc/eProvider/providerLogin.do)

If you don't have credentials for Provider Connect, you will need to reach out to your agency's Super User who can provide you with that information.

If you do not know who your Super User is, please contact Brian Erdoes (brian.erdoes@beaconhealthoptions.com) with Beacon Health Options informing him that you are with an IDD provider and you need to identify your agency Super User.

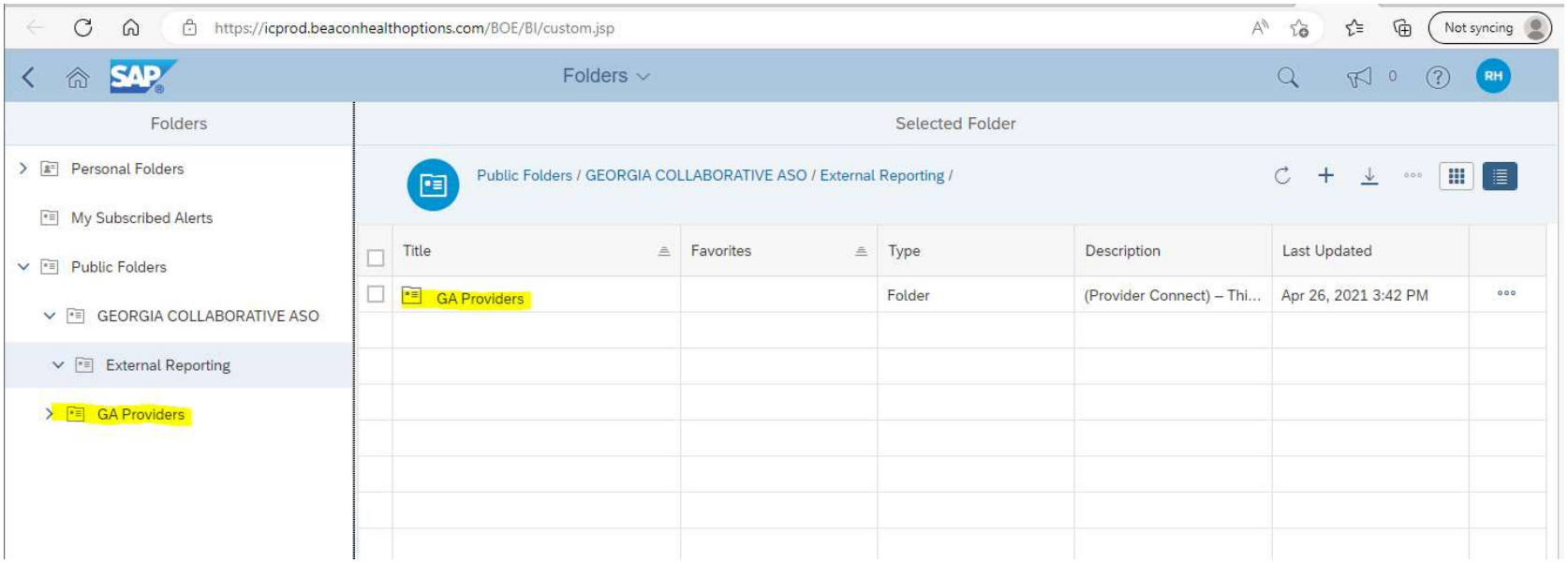
How to Access IDD Reports

Once logged into Provider Connect Portal, access reports by clicking on the “Reports” link on the lefthand navigation panel.



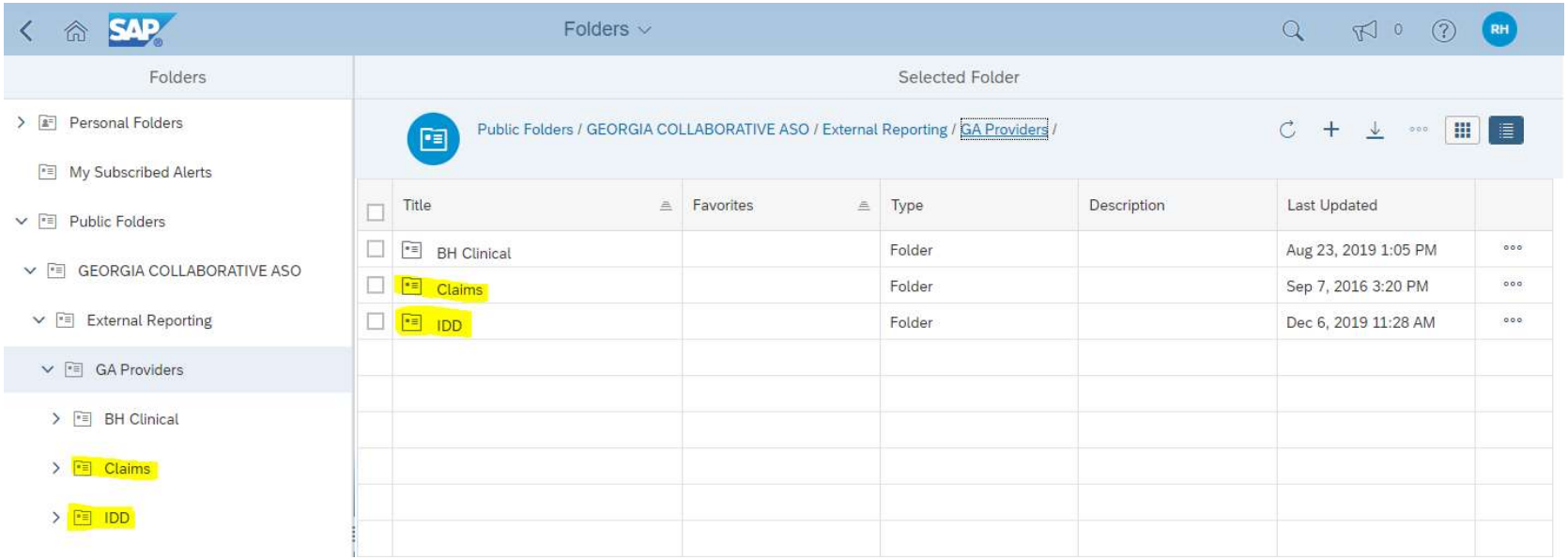
How to Access IDD Reports

This will open the IntelligenceConnect reporting tool (Webi).



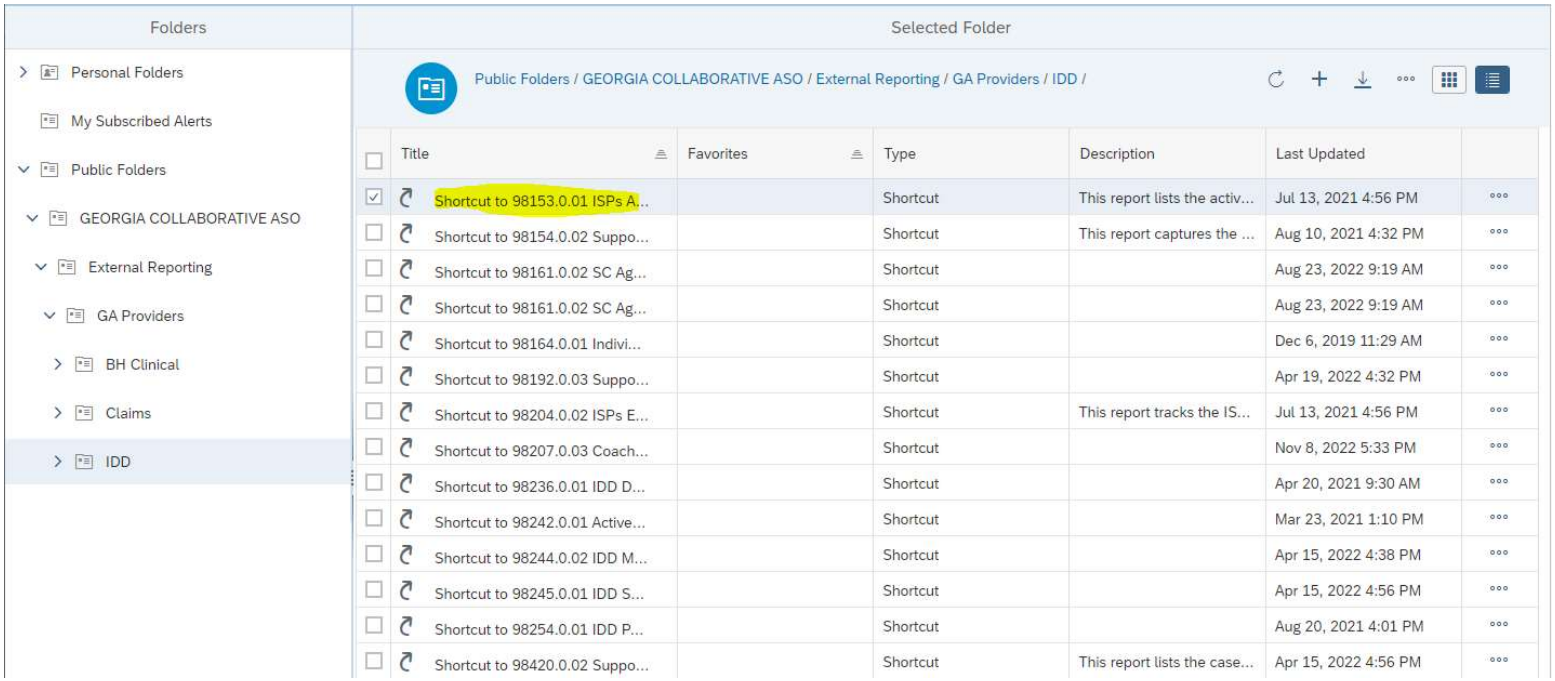
How to Access IDD Reports

The GA Providers folder has sub-folders for BH reports, IDD reports and claims reports. IDD providers will find reports in the IDD and Claims folders.



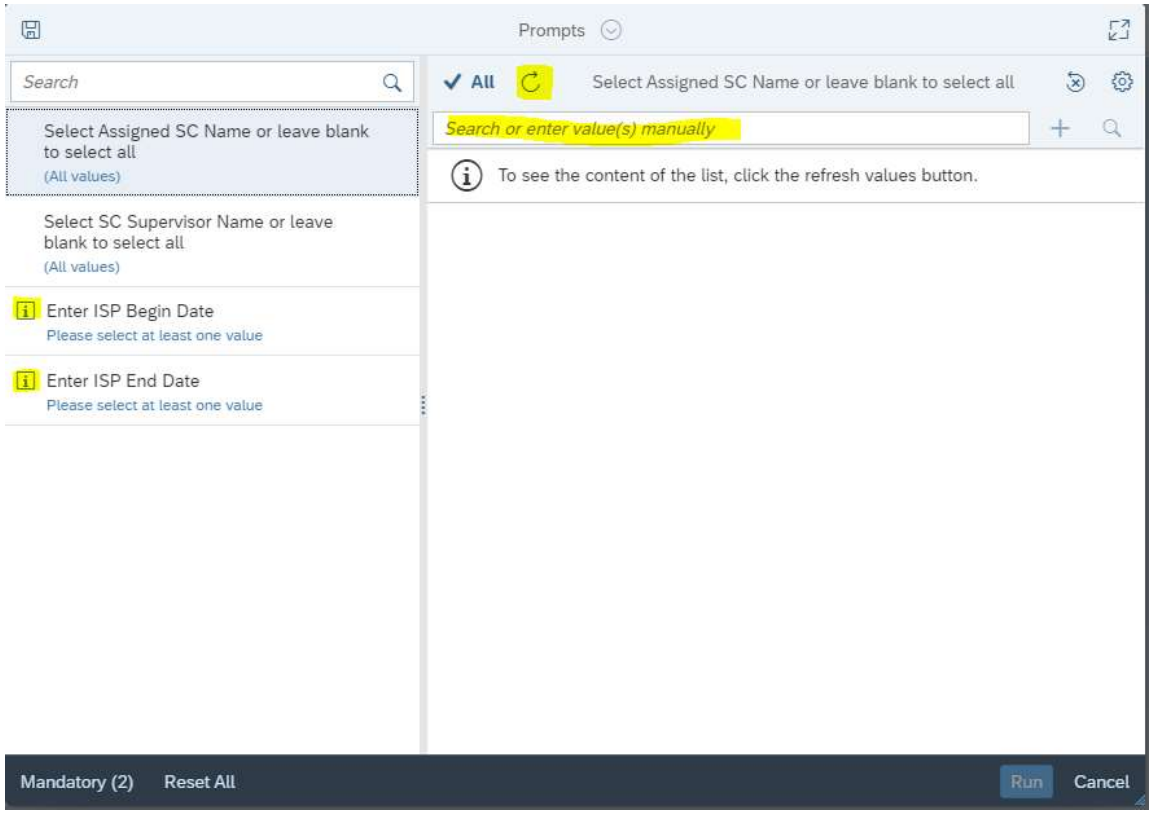
How to Access IDD Reports

Find the report you are wanting to run and right-click on the report name and select “View” from available options.



How to Access IDD Reports

Enter any required or optional parameters as needed (if prompted).

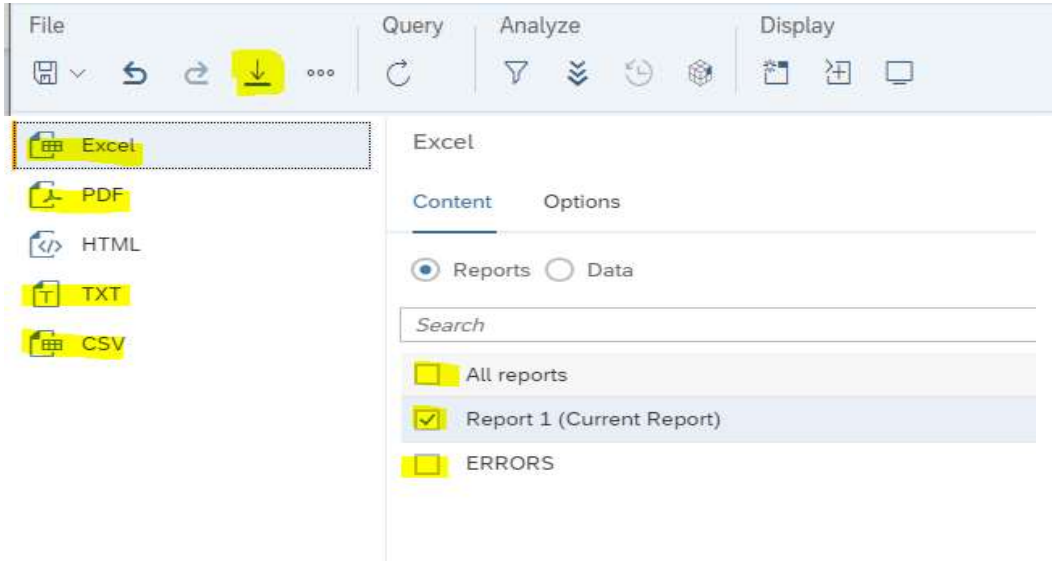


- Required parameter are identified with “I”.
- Some parameters may require you to select from a dropdown list. To refresh the list, select the circular arrow.
- Some parameters can be manually entered.

How to Access IDD Reports

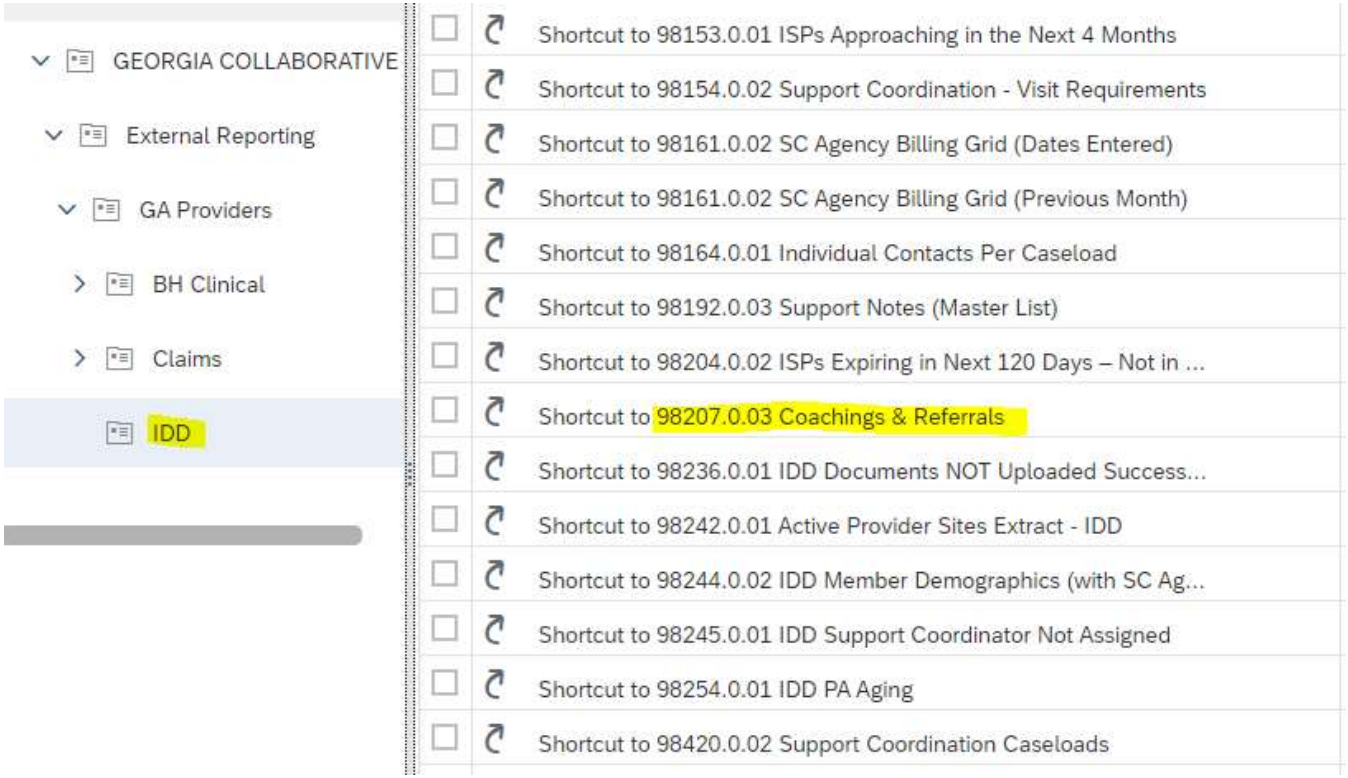
Once the report has finished running, the report can be download in various formats.

- Select the download arrow from the menu bar.
- Select the file type you would like
- Select the pages you would like and press “Export”.



Reports of Interest to Providers

Coachings & Referrals – this report provides information related to Coachings/Referrals as documented in IDD Connect.

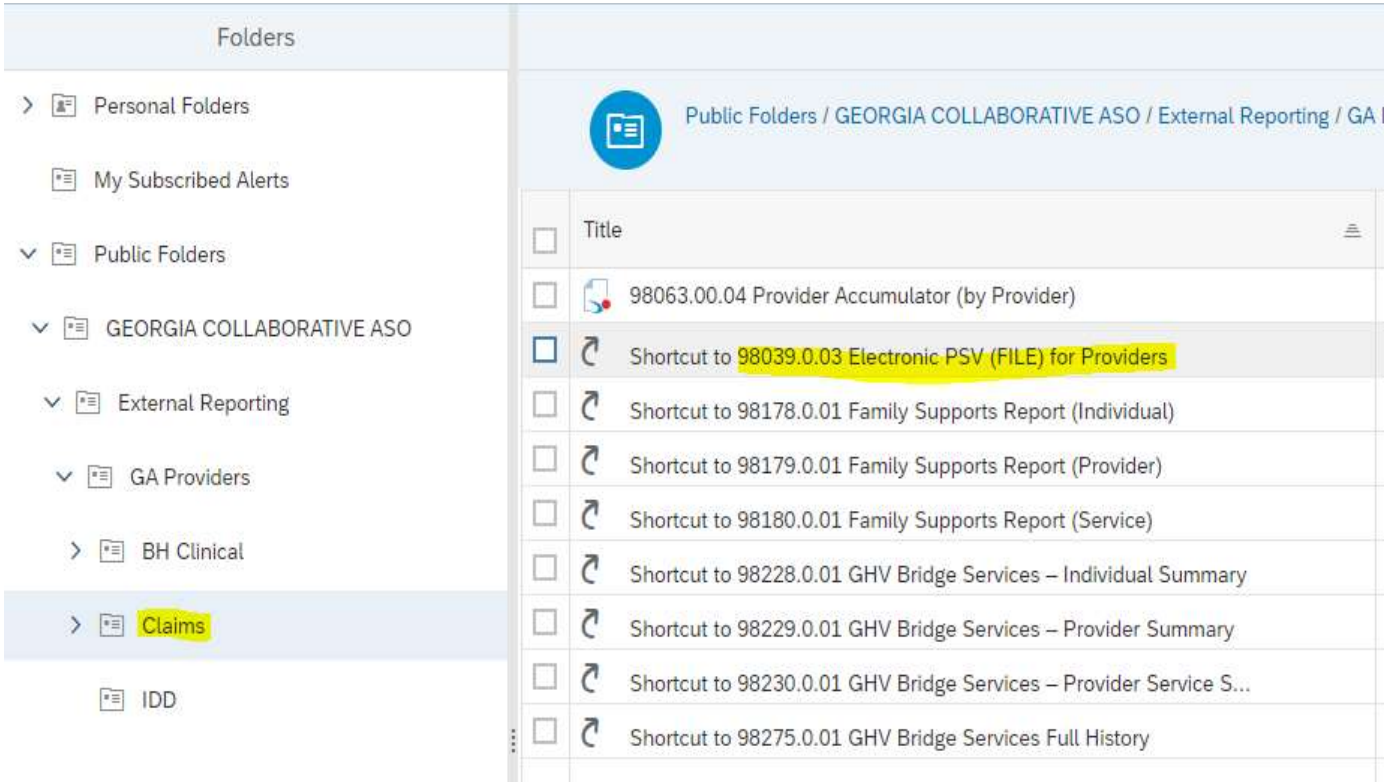


Parameters:

- Has multiple parameters that can and should be used to narrow focus.
- There is a lot of historical data in the system which may cause the report to run long if focus isn't narrowed.

Reports of Interest to Providers

ePSV – this report provides a download of each week's claims that were processed by Beacon. Does not include Medicaid claims.



Parameters:

- MUST enter Beacon provider ID (begins with GAC_____).
- Paid Date – claims are only processed on Tuesdays thus the date must be a Tuesday.

Will only contain claims processed in the previous week.

How to Access IDD Reports

Demonstration

How to Access IDD Reports

If you experience any difficulties or have any questions, you may contact:

Reporting Team Lead:
Tearese Mitchell - tearese.mitchell@dbhdd.ga.gov.

Director of Data Management & Reporting:
John Quesenberry – john.quesenberry@dbhdd.ga.gov

Office of Health and Wellness (OHW) Updates

Dr. Dana Scott, DNP, RN

Director Office of Health & Wellness, Division of Disabilities

Georgia Department of Behavioral Health & Developmental Disabilities

HCP vs Risk Mitigation Policies

Healthcare Plans for Individuals with Intellectual/Developmental Disabilities (I/DD) in Community Residential Alternative, and Community Living Support Services with Skilled Nursing Services, 02-266

Policy 02-266

Applicability:

- All Intellectual/Developmental Disability (I/DD) Providers- in Community Residential Alternative Services and Community Living Support Services Providers who are authorized to provide Skilled Nursing Services.

Revisions:

- Definitions of Individual and provider
- Improved outline format
- Procedures-from all settings to specific settings
- Additional information to be considered in the HCP
- Elements of the HCP

Elements of a Healthcare Plan:

Elements
Demographic Information
Effective Date
Diagnosis
Description of Symptoms of Exacerbation of Condition
Nursing Diagnoses
Goals and Objectives (Standards of Care)
Interventions
Documentation and Location
Evaluation of Progress
Signature of RN

Risk Mitigation of Health Conditions or Vulnerabilities in Intellectual and/or Developmental Disability (I/DD) Services, 02-807

Policy 02-807

Applicability:

- All Intellectual/Developmental Disability (I/DD) Community Service Providers with the exception of Community Residential Alternative Service Providers and Community Living Support Service Providers providing services to individuals who have authorized Skilled Nursing Services.

Revisions:

- Definitions of At Risk Conditions, Risk Mitigation Document, and Vulnerabilities
- Elements of the Risk Mitigation Document
- Procedures- timeframes of updates and reviews, training staff, and documentation sources

Elements of a Risk Mitigation Document:

- Date of creation
- Date of any applicable updates to the document
- Individualized demographic information
- Allergies or No Known Allergies (NKA)
- Statement and description of known condition, risks, and diagnoses
- Any applicable individualized action steps to be taken when needed
- Communication Plan
- Contact details for primary caregiver and responsible parties

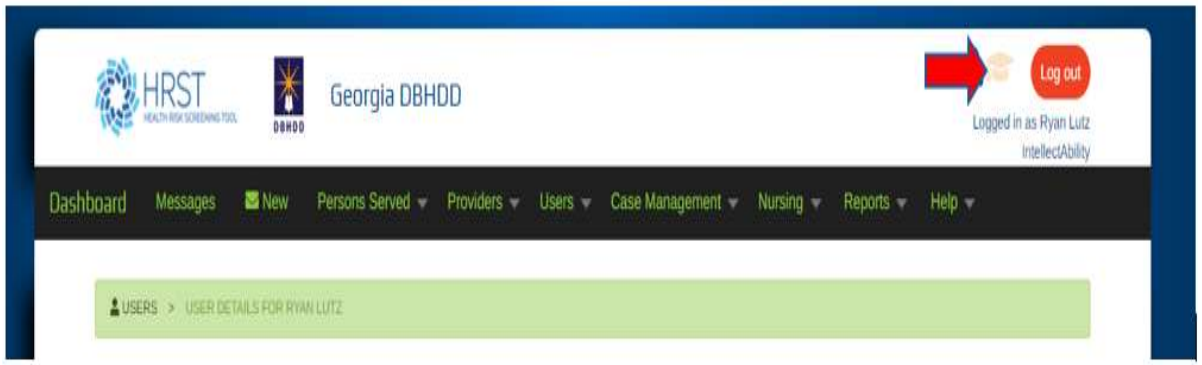

Updates Regarding Covid

Office of Health & Wellness
Provider Training Announcements

How do users request training in HRST Application

A user can request trainings directly in HRST Application. This allows a user to request trainings for themselves only and not on behalf of any other user.

Click on the training cap icon in the top right corner of HRST to automatically navigate to the Training Tab to request training under Available Courses



HRST Advanced Rater In-app Training

Existing Raters

Any Rater who has an Online Rater Training completion date before May 16, 2022 must complete the HRST In-App Advanced Rater Course by May 16, 2023. There are still over 2,000 Raters that need to complete course to maintain HRST Rater Role. Click on Training Cap in HRST and navigate to My Assigned Courses to complete.

Send questions to gasupport@replacingrisk.com

Health Risk Screening Tool (HRST):
One Day Training for Clinical Reviewers Webinar
TRAINING PREREQUISITE:

ALL attendees planning to attend this training must successfully complete BOTH the HRST Online Rater Training and in-app Advanced Rater Training, and have an IDD Connect Account Username.

Next Clinical Reviewer Training is March 7th

Dangerous Mealtime Practices

Office of Health and Wellness & our ICST Nutritionist have updated the curriculum for Dangerous Mealtime Practices. If your agency is interested in participating in the 2023 In Person Train-the Trainer Course presented by DBHDD ICST Registered Dietician/Nutritionist please email Karen Cawthon: karen.cawthon@dbhdd.ga.gov .

Office of Waiver Services Updates

Ashleigh Caseman
Director of Waiver Services
Office of Waiver Services

February 9, 2023

Georgia
Department of
Behavioral Health
& Developmental
Disabilities

Today's Topics

- Rate Study
- IDD Study Committee
- Appendix K- Unwinding
- COMP & NOW Renewals Updates

What is a Rate Study?

A rate study is a comprehensive review of provider payment rates and billing policies.

- The rate study considers policy goals, provider costs and operations, and cost data from other reliable sources.
- Rate models are developed based on assumed costs for key factors such as wages and benefits for direct support professionals, agency administration, and other program expenses.
- States are required to use and explain to CMS valid rate methodology's that are employed to establish provider payment rates for waiver services when a state request a waiver amendment/renewal

DBHDD has contracted with Burns & Associates, a division of Health Management Associates (HMA-Burns), to assist with the rate study

Why is DBHDD Completing a Rate Study?

- The rate study is part of the state's federally approved ARPA spending plan—Georgia committed to conducting a rate study as a condition of receipt additional HCBS funding authorized by the ARPA through CMS.

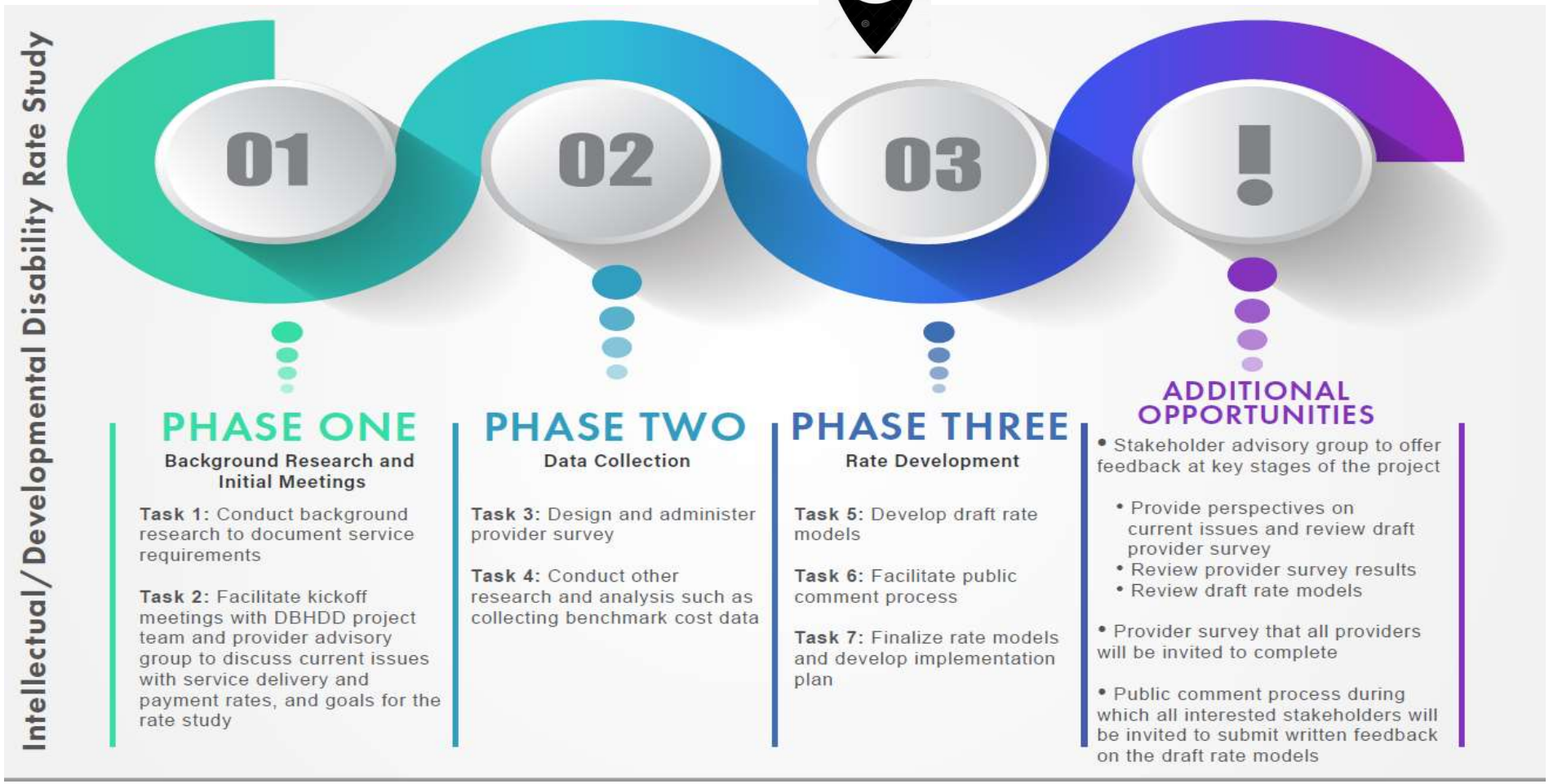
- CMS requires states to demonstrate valid provider payment rates for waiver services as part of the application approval process- which includes having current rate setting.

- In the FY2023 budget, the General Assembly directed DBHDD to conduct the rate study for all NOW and COMP waiver services

- It has been over a decade since a comprehensive rate study has been conducted. Payment rates for a few services (group homes, host homes, community living supports, and respite) were reviewed in 2015 and updated in 2017. The rates for most other services have not been reviewed for more than 10 years.

- SB610

Rate Study- Timeline



Goals of Independent Rate Model Approach

Rate models should reflect the reasonable costs providers incur to deliver services consistent with the state's requirements and individuals' service plans.

The study considers data from multiple sources rather than depending on any single source

- **Policies, rules, and standards**
- **Provider and stakeholder input** (e.g., provider survey, public comments)
- **Published sources** (e.g., federal wage data and mileage reimbursement rates)
- **Special studies** (e.g., benchmarking rates to other states' programs)

Rate models are developed independent of budgetary considerations

- Cost impact will be considered as part of implementation planning

Highlights of the DRAFT Rate Study

The DRAFT rates would increase provider revenues by 40 percent overall

- Specific changes vary by service
- The DRAFT recommendations include rate reductions to a small group of services.
  - *Even if the final recommendations include rate decreases, ARPA prevents implementation of any rate reduction before 2025*

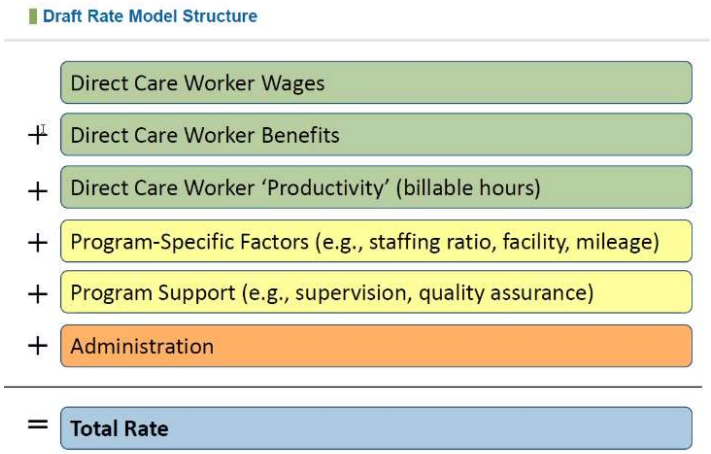
- Fiscal Impact Estimates have been developed and are being disseminated amongst various stakeholders. The estimated fiscal impact of proposed rates based on Fiscal Year 2021 claims data can be accessed here:

https://www.burnshealthpolicy.com/GeorgiaWaiverRates/

Highlights of the DRAFT Rate Study (cont.)

Rate study aims to improve compensation for Direct Service Professionals (DSPs)

- Rate models assume an average DSP wage which is inclusive of the following:
  - **more than $15 per hour**
  - **Comprehensive benefits**
  - **25 days paid leave**
  - **Access to health insurance**



- Stakeholders called for additional increases in public comment.

Highlights of the DRAFT Rate Study (cont.)

Rate study aims to encourage employment and community-based supports (versus facility-based services).

- Rate Study recommends changes to payments for **Supported Employment and Community Access** (day programming) to increase payments for individuals who need more support.
- Rate study proposes higher rates for **Community Access** services provided in the community compared to facility-based services.
  - Currently a single rate regardless the person's support needs.

Highlights of the DRAFT Rate Study (cont.)

Rate study aims to improve the quality of support for individuals with more significant needs

- 2015 rate study established ‘tiered’ rates for group homes and host homes
  - Higher rates paid to providers serving individuals with greater assessed needs
- Rate study proposes a similar approach for Community Access-Group and Supported Employment-Individual services
  - Current rates pay providers the same regardless of individuals’ needs, potentially limiting options for those who require more intensive supports
- Rate study also proposes higher rates for providers employing staff conversant in American Sign Language to serve individuals who are deaf or hard of hearing

Highlights of the DRAFT Rate Study (cont.)

Rate study proposes upper limit on wages for participant-directed staff

- Goal is to ensure compliance with federal requirements that payments be "economic" and "efficient" and to prevent individuals from spending through their budgets too quickly
- Hourly wage limits would be about $26 for Community Living Support, $27 for Community Access, and $22 for Respite

Rate study also proposes to eliminate personal assistance retainer

Highlights of the DRAFT Rate Study (cont.)

Rate study proposes to increase budget limits for several supports

- Assistive Technology – increase from $1,195 to $2,000
- Environmental Modifications – increase from $10,400 once per lifetime to $15,000 every five years
- Vehicle Modifications – increase from $6,420 once per lifetime to $15,000 every five years

Process Flow- Next Steps

The public comment for draft recommendation period ends Friday, January 20, 2023

Burns and Associates will analyze public comment- present findings DBHDD

Final rate tables adopted by DBHDD

-appropriation-

DCH Board (initial adoption, public comment, final adoption)

Waiver Amendment to CMS

Waiver Amendment RAI/IRAI (Request for Additional Information)

New Models and Rates Operationalized by DBHDD and DCH

BURNS & ASSOCIATES

A DIVISION OF

HEALTH MANAGEMENT ASSOCIATES

NOW and COMP Rate Study – Initial Recommendations: Fiscal Impact Addendum

- prepared for -

Georgia Dept. of Behavioral Health and Developmental Disabilities

February 6, 2023

Overview of Fiscal Impact Analysis

- HMA-Burns has developed a service-level fiscal impact analysis to estimate the cost to the state to fully implement the draft rate models

- At full implementation, the draft rates represent an overall rate increase of about 38 percent, which would increase total funds costs by $267 million annually
  - Baseline cost estimates are based on permanently authorized rates and exclude temporary rate adjustments (such as a temporary ten percent rate increase for many services authorized on March 1, 2021)
  - The estimate represents state payments to providers; it does not attempt to quantify impacts to individual providers' costs or margins
  - Impacts vary by service since rates are changing by differing amounts, and by provider based on the services they deliver and individuals they serve
  - HMA-Burns and DBHDD are currently considering public comments and will update the analysis once the rate models are finalized

Fiscal Impact Analysis Methodology

- The estimate reprices fiscal year 2021 utilization levels as if the proposed rates had been in effect
  - The estimate does not assume any changes to utilization patterns (e.g., the total cost will be greater if utilization increases)

- For services for which there are no changes to billing policies, the analysis simply compares the current and draft rates; for services for which the rate study recommended changes to billing policies, assumptions are detailed in the notes that accompany the estimates)
  - These assumptions rely on analysis of claims, data collected through the provider survey, and individual assessment data

SR 770- IDD Study Committee

- Created a Senate Study Committee for people with Intellectual and Developmental Disabilities to:
- Evaluate the impact of the growing population in Georgia which results in an increasing demand for services for Georgians with IDD;
- Address the need to understand and address shortfalls in the DSP workforce;
- Develop a flow of capital investment resources targeted at the development of a comprehensive service structure, to include adequately trained workers
- The Committee Held series (6) of public forums Summer/Fall 2022 around the state of Georgia

- Final recommendations released December 2022.
- To view the final report:
  IDDFinalReport12.14.22.pdf (ga.gov)

Appendix K- Unwinding

- National Public Health Emergency (PHE) is anticipated to end on May 11, 2023. This announcement aligns with the administration's previous commitments to give at least 60 days' notice prior to the termination of the PHE.

- Please note that the Appendix K allowances are aligned with the federal PHE. Importantly, the flexibilities and enhancements which are supported by the Appendix K for the NOW and COMP Medicaid Waiver programs **will remain in effect for up to 6 months after the end of PHE (November 11, 2023).**

Appendix K- Unwinding

Maintained Post Appendix K

- Appropriations increases (5% FY22 2% FY23)
- Telehealth for specific services
  - Adult Therapies & Nutrition
  - Interpreter Services
  - BSS (for some tasks)
  - SEG/SEI (for some tasks)

Allowed to expire with Termination of Appendix K

- All temporary rate increases that were not tied to a state appropriation
  - 3/1/2020 SC, FI, LPN
  - 3/1/2021 CRA, CLS, CAG
- Alternate Settings
- Telehealth for RN, SC/ISC and Community Access
- Family Caregiver Hire with exception of extenuating circumstances (pre PHE)
- Staffing patterns flexibilities
- All other items as distinguished in the Appendix K and Operational Guidelines

COMP & NOW Waivers– Updates

COMP:

- COMP amendment includes 5% and 2% increases anticipated to go to DCH board for initial adoption February 2023 (updated from original date December 2022)
- COMP Renewal approved on July 14,2022 is currently being incorporated into DCH and DBHDD policy and operations.

NOW:

- NOW renewal approved by DCH board for final adoption on July 18, 2022
- Goal to align with approved COMP changes where possible
- NOW renewal Submitted to CMS by DCH on August 2, 2022
- UPDATE: Several NOW renewal provisions were removed from NOW application as part of ARPA MOE requirements
- CURRENT STATUS: Pending CMS Approval
- Note: the NOW renewal includes same permanent telehealth options as COMP renewal and the 5% and 2% Rate Increase from FY22 and FY23 state appropriations in preparation for unwinding the Appendix K

NOW COMP Waiver Application Performance Measures (NCW) Review

Nancy Overs-Ikard ASO IDD Director of Quality and Ashleigh Caseman DBHDD Director of Waiver Services

Agenda

01 Overview of the NOW and COMP Waiver Application Performance Measures (NCW) tool

02 Changes to the NCW review process based on the COMP Renewal

03 The GA Collaborative ASO request of documentation

04 Resources and links

Overview of the NOW and COMP Waiver Application Performance Measures (NCW) Review

Data Collection Tool for Waiver Performance Measures

NOW COMP Waiver Application Performance Measures (NCW)

Key Waiver Assurances Areas	Documentation Used to Score
Assessments	DMA-7 or DMA-6 HRST
Service Plan	ISP Individual 360 ISP Signature Page
Service Delivery	Provider's Progress Notes
Health and Safety	Abuse, Neglect, and Exploitation Preventative Healthcare Restrictive Procedures Post Hospitalization Follow-Up

https://www.georgiacollaborative.com/providers/intellectual-developmental-disabilities-providers/

NOW and COMP Waiver Application Performance Measures (NCW) tool and process (Updates)

NCW Review Tool Changes

Health and Safety Area

(new indicator)

The individual received the prescribed medication as indicated by the medication administration records (MAR).

- Indicator applies to Community Residential Alternative (CRA) service
- Quality of Care Concern

Quality of Care Concern (QCC) Process

- A QCC may be identified for the following:
  - Missing medication administration records (MAR)
  - Medications not provided as ordered by the physician

- If identified, the Quality Assessor will notify the provider of the findings and schedule a QCC Quality Technical Assistance Consultation (QTAC) within 30 days of the finding.

Requesting Documents for the NCW Review

Documents for NCW Reviews

For individuals selected for the NCW review, the provider will receive the following documents:

- NCW Individual key
- NCW Documentation Checklist

NCW Request for Documentation

NCWs included in QEPR review

- QEPR lead submits request for documentation at the QEPR entrance

NCWs not included in QEPR review

- Provider receives email notification requesting NCW documentation

Providers NOT Selected for a QEPR

The provider will receive a NCW email notification that includes:

- The purpose for requesting documentation
- How to submit documentation requested through the secure share email system
- The timeframe for submitting documentation

The provider will receive the following NCW documents through the Proof Point Secure Share email system:

- Individual key (List of individuals selected for the NCW review)
- Documentation Checklist (list of documents to submit)

Options for Submitting Documentation

100% Electronic Medical Record (EMR)

- Uses an EMR for documentation for individuals
- EMR system can be accessed remotely
- Assigns the Assessor a unique log-in and password

Paper

- Paper is used for documentation for individuals or there is an EMR but it cannot be accessed remotely
- Providers will be responsible for sending all documentation via secure email or eFax

Record Submission Process

100% EMR

- Once the Individual Key is received, the provider has 2 hours to grant access to individuals' EMR and send User Name and Password for the Quality Assessor.

Record Submission Process

Paper

- **Individual Records**: Once the Individual Key is received, the provider has until 4:00 pm to send the requested documentation

Options to Submit Paper Records

The Proof Point Secure Share email system for quick and secure submission of scanned documentation directly to the Quality Assessor

The secured RightFax (electronic fax) system is another option to submit scanned or faxed documents

Resources

The Georgia Collaborative ASO website:

https://www.georgiacollaborative.com/providers/intellectual-developmental-disabilities-providers/

Thank You

Contact Us

855-606-2725

www.georgiacollaborative.com

GAQuality@beaconhealthoptions.com

Crisis Stabilization and Diagnostic Center (CSDC)

BE D·B·H·D·D

Georgia Department of Behavioral Health & Developmental Disabilities

Beth Shaw
Mercedes Brown, PhD, BCBA
February 9, 2023

D·B·H·D·D

Agenda

- CSDC Recap
- CSDC Updates

CSDC Recap

16 bed, short term (24/7) crisis stabilization facility for adults with I/DD

Interdisciplinary assessment and service planning

Support individuals with high levels of acuity

Behavioral, Medical, Pharmacological and many more!

CSDC Recap cont.-Service Provision

Primary Services

- Psychiatry
- Medical (Physician and Nursing)
- Behavioral Services (BCBA-D and RBT's)
- Direct Support Staff
- Counseling (Psychologist/Counselor/Therapist)
- Case Management

Secondary (Contracted) Services

- Neurology
- Dental
- Ophthalmology
- Endocrinology
- Audiology
- OB/GYN
- Podiatry
- OT/PT/ST
- Specialized lab services
- Genetic Testing
- Nutritionist
- X-ray
- Allergist

YOU!

"Working together IS success!"

-Henry Ford


CSDC Updates

CSDC Updates

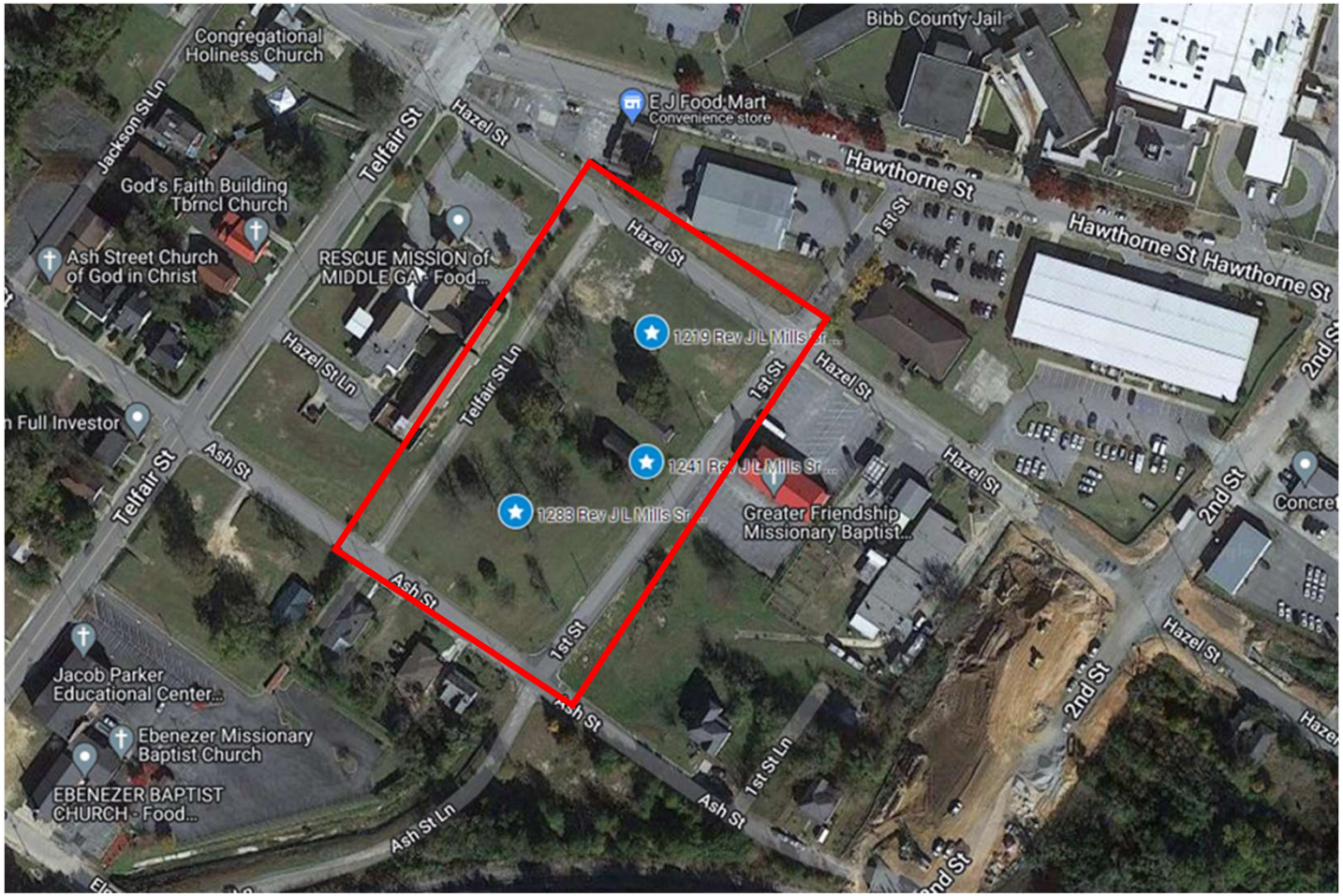
- Engagement w/ community partners
- Visited and Toured 2 facilities in Kentucky
- Operational and Clinical Standards have been developed
- Floor Plan (final stages)
- Construction Phase

Visual of Location

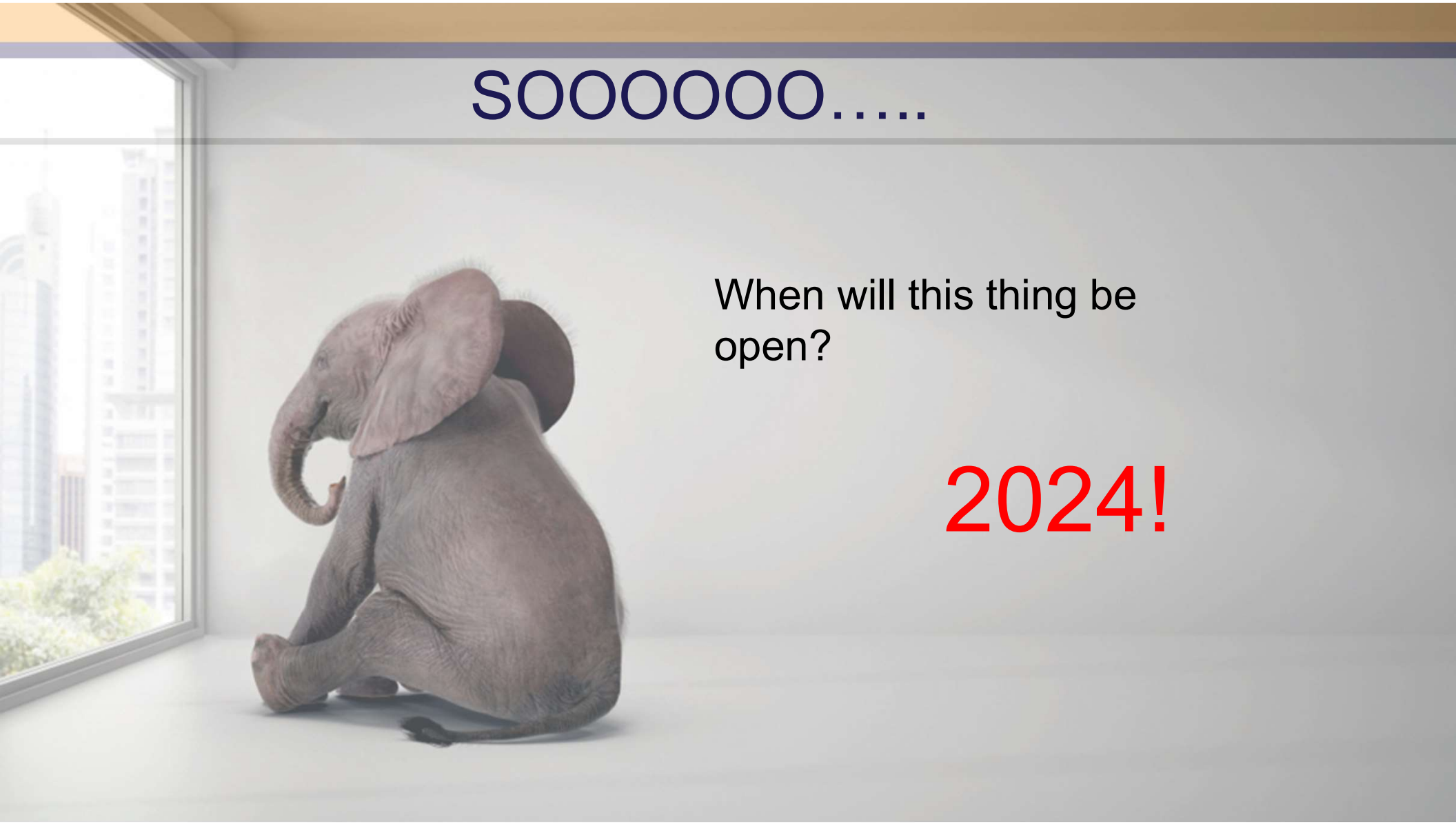
Located on Rev. J L Mills Senior Way in Macon-Bibb County

Centrally located within the state

World-class healthcare and educational institutions nearby



SOOOOOO…..



When will this thing be open?

2024!

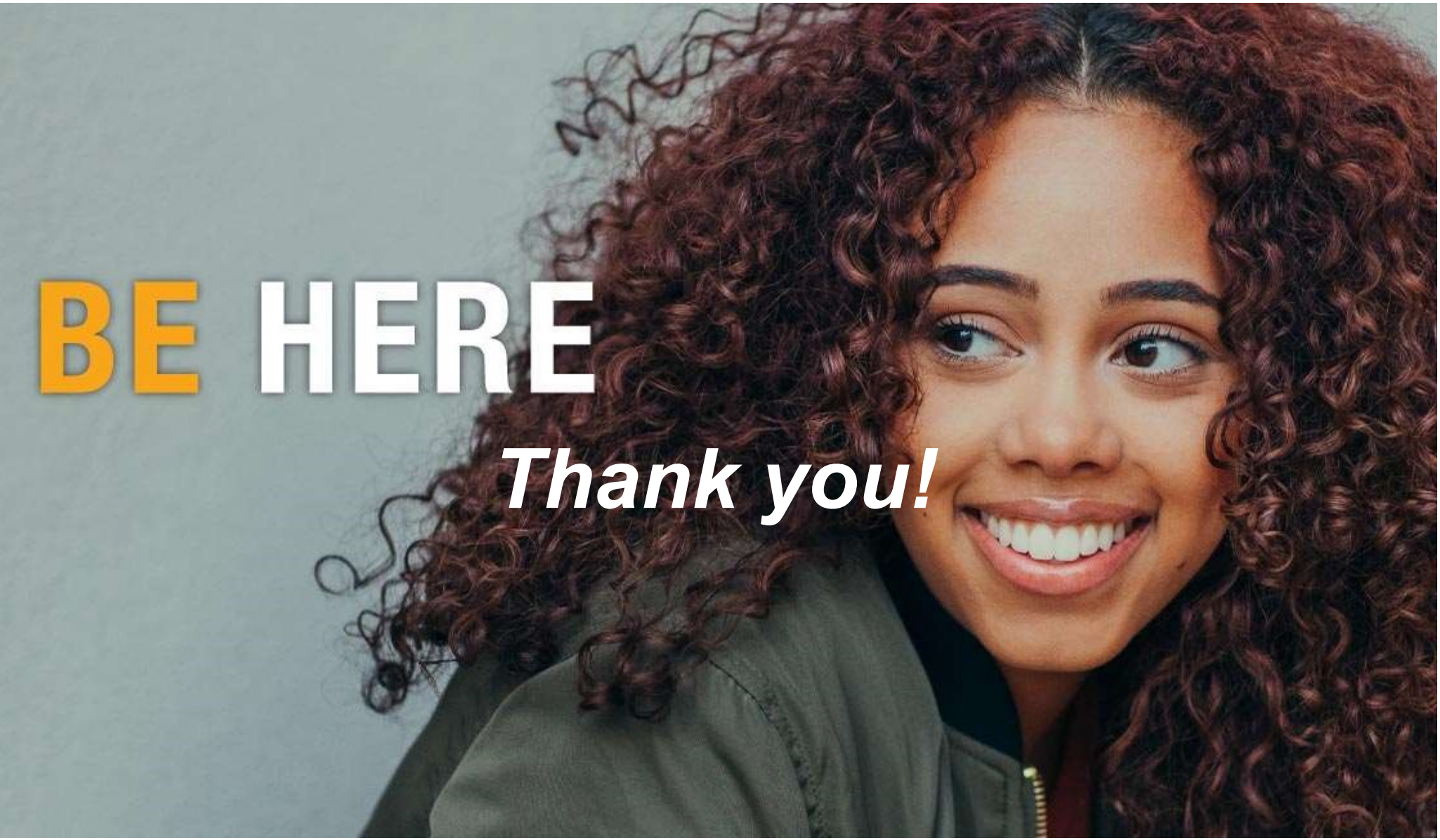
Provider Q & A

BE D·B·H·D·D

Georgia Department of Behavioral Health & Developmental Disabilities

Next Quarterly All-State IDD Provider Meeting scheduled for MAY 11, 2023

D·B·H·D·D


BE HERE
Thank you!