Care Resources PACE Provider Manual

Our Mission:

Care Resources' mission is to offer long-term care choices that promote independence, dignity and a high quality of life for the frail elderly members of our community.

Holland Home™ PINE REST METRO HEALTH UNIVERSITY OF MICHIGAN HEALTH Dominican Sisters Grand Rapids, Michigan *Emboldened by faith, serving with joy* RELIANCE COMMUNITY CARE PARTNERS™

Rev 01/07/2022

Table of Contents

Chapter

1

Introduction

Welcome to Care Resources! As a contracted provider of services you have a special place in Care Resources PACE®. Through efficient and effective use of our services that focus on enhancing the participant's functional capacity, we can achieve our program goal of managing the frail elderly in their community as long as it is socially, medically, and economically feasible.

The purpose of this manual is to familiarize participating providers and their office staff with the daily operations of Care Resources. It is designed as a reference tool to assist you with the administrative tasks related to accessing and providing comprehensive, effective, and quality medical services to Care Resources participants. Care Resources reserves the right to revise these policies and procedures at our sole discretion herein and at any time.

Overview of Care Resources

Care Resources is a Program of All-inclusive Care for the Elderly (PACE), a comprehensive benefit of health and social services for the frail elderly authorized by the Balance Budget Act of 1997. Care Resources provides community-based services to the frail elderly who reside in Kent County and specific Allegan, Barry, Ionia or Ottawa County zip code areas.

Care Resources, the Centers for Medicare and Medicaid Services (CMS) of the United States Department of Health and Human Services and the State of Michigan partnered in creating a unique system of managed care for the frail elderly and founded Care Resources. Part of the national Program of All-inclusive Care for the Elderly (PACE), Care Resources goes beyond traditional boundaries of elder care, providing medical and support services with a distinct preventative care focus to help participants avoid illnesses and costly hospitalizations.

To be eligible to enroll as a Care Resources participant, an individual must:

1. Be 55 years or older

2. Resident of Kent County or these select zip codes in Allegan, Barry, Ionia, and Ottawa Counties:

48809, 48815, 48846, 48849, 48865, 48881, 48897, 49058, 49302, 49315, 49316, 49323, 49325, 49328, 49331, 49333, 49344, 49348, 49418, 49428, 49435, 49534, 49544

3. Be able to live in the community without jeopardizing their health or safety, and

4. Meet the Nursing Facility Level of Care Eligibility for Long-term Care Placement in Michigan

Upon enrolling in Care Resources, all of his or her services must be authorized and coordinated by the Care Resources Interdisciplinary Team. This feature, known as "lock-in" ensures coordinated, comprehensive service delivery. In exchange, Care Resources assumes full financial responsibility for all medical needs of its participants.

The participant's care is planned and directed by an Interdisciplinary Team that consists of physicians, registered nurses, therapists, dietitians, social workers, pharmacists and others trained in geriatric medicine. Care is focused on preventive services and functional maintenance as well as ongoing medical care. Periodic assessment by the interdisciplinary team keeps the plan of care and service delivery on track.

Care Resources offers a full range of services which include, but are not limited to, medical and social services received at the adult day health center, home care, inpatient services through Metro Health Hospital, nursing home care through local providers, primary medical care, drugs, laboratory tests, x-rays and durable medical equipment. There are no deductibles or co-payments for covered services, including prescription medications.

Mission and Values

Mission Statement

Care Resources' Mission is to offer long-term care choices that promote independence, dignity and a high quality of life for the elderly members of our community.

Values

- Preserving the quality of life is our commitment to the people we serve.
- A holistic approach that embraces a person's physical, mental and social health.
- Responsiveness to the people we serve by continually addressing their needs.
- Collaboration through partnerships to utilize community resources to help the people we serve to remain in their home.
- To be good financial stewards of limited health care resources.

The History of Care Resources

In June 2000 the Michigan Long Term Care Work Group (comprised of four legislators and four senior officials of the Michigan Department of Community Health) issued a report and subsequent recommendations regarding Medicaid financed long-term care services. The report recommended the establishment of integrated service delivery systems in order to improve access, choice, quality of care, quality of life, and cost with regard to long-term care services. The report recommended the establishment of PACE programs as an element of the continuum of services available in integrated service delivery systems. In order to respond to the recommendations of the work group, four local Grand Rapids long-term care providers formed a partnership that eventually became Care Resources.

In June of 2001, Care Resources received a grant from the Michigan Department of Community Health to develop an integrated service delivery system for a twelve (12) county area of Western Michigan using the Regional Provider Organization (RPO) administrative model. During the planning and development of the RPO Care Resources became aware of a local religious order, the Grand Rapids Dominicans, that was interested in developing a PACE program to serve retired members of their order.

After completion of a PACE feasibility study in the fall of 2002, Care Resources restructured itself to focus on developing a PACE program in Kent County. Two of the initial Care Resources partners withdrew and three new partner organizations were added.

Currently, the five (5) Care Resources PACE partners are:

Reliance Community Care Partners:

Reliance Community Care Partners (Formerly HHS, Health Options®) began in 1979 as a project of the Junior League of Grand Rapids to explore ways of improving the quality and access to in-home health care for older adults. The company was incorporated in 1980 as a non-profit organization focused on providing service-neutral case management services that ensured objective management across the entire continuum of care. Subsequently, Reliance Community Care Partners obtained a grant to implement a comprehensive program of caregiver support and coordination of community resources which bridged gaps in the location of services for in-home care, respite services, and relief to over-burdened caregivers.

Reliance Community Care Partners has been a home and community based waiver services provider in a 12 county area of Western Michigan, including Kent County, since 1993.

Holland Home:

Holland Home provides faith-based services for every level of long-term care need –from independent living, to assisted living, to skilled nursing care. Holland Home also provides a continuum of care for individuals with Alzheimer's and dementia related disorders. In addition

to being a continuing care retirement community, Holland Home also provides home care and hospice services. Holland Home has operated in the Grand Rapids area since 1892.

Holland Home operates 236 licensed assisted living (Home for the Aged) beds and 159 skilled nursing beds that serve Medicare and Medicaid eligible individuals. All individuals served in this capacity are Medicare eligible and many residents also receive Medicaid benefits.

Grand Rapids Dominican Sisters:

The Grand Rapids Dominicans are comprised of approximately 300 vowed religious women who uphold Dominican tradition of empowering others in the pursuit of truth and the fourfold elements of Dominican Life: prayer, community, study, and service. The main residence or "motherhouse" was built in 1922 and is located on a 34-acre campus setting (referred to as "Marywood"), in Grand Rapids. This site houses approximately 100 women living independently as well as 38 women needing different levels of nursing care.

The Grand Rapids Dominicans are not a service agency and therefore do not have a history of serving Medicaid or Medicare clients. Many of their members are eligible for and enrolled in Medicaid and Medicare however.

Pine Rest Christian Mental Health Services:

Pine Rest is a nonprofit organization founded in 1910 located on a 220-acre main campus just outside Grand Rapids in Cutlerville. It is one of the largest free-standing behavioral health providers in the United States. They offer a full continuum of services including inpatient and partial hospitalization, psychiatric urgent care, residential and outpatient services, addiction treatment and recovery, extensive child and adolescent programs, senior care services, as well as specialized assessment and treatment clinics. Pine Rest clinicians offer therapeutic services in behavioral health across the continuum of care within a Christian framework. Pine Rest has 21 outpatient locations plus teletherapy.

University of Michigan Health-West:

University of Michigan Health-West (formerly Metro Health) opened its doors to the community in 1942. Formed by a small group of osteopathic physicians and originally named Grand Rapids Osteopathic Hospital, it was founded on the principles of holistic and patient-centered care. They opened a 28-bed osteopathic hospital in a converted house in Grand Rapids.

Today, that hospital has grown into the 170-acre Village, anchored by the 208-bed acute care teaching hospital, University of Michigan Health-West, and a network of 30 community-based centers and offices throughout West Michigan.

Care Resources:

Care Resources, is a 501(c)(3) corporation founded on October 1, 2006 and comprised of one appointee from each member organization. Care Resources draws its expertise and experience in the delivery of long-term care and health care services from the rich and successful history of its partner organizations.

Programs of All-Inclusive Care for the Elderly (PACE) are a Medicare and Medicaid funded option that gives community-based coordinated care and services to older adults, helping to stay safely in their homes. PACE provides coverage for prescription drugs, physician care, transportation, home care, hospital visits, and nursing home stays when necessary.

The five partner organizations, all not-for-profit organizations with experience serving the elderly and disabled, are the sponsoring organizations for Care Resources and delivers through contractual arrangements the majority of PACE services.

Care Resources intends to serve as many PACE participants as the market will allow and will grow in conjunction with the State of Michigan's long term care goals and resources. Care Resources currently serves 250-300 participants in their PACE center location at 4150 Kalamazoo Avenue.

Provider Manual Updates

This manual will be updated regularly as policies and procedures change. Updates will be distributed as they occur.

Please be sure to replace the existing pages in the manual upon receipt of any updates. This will assure that the information available is current.

We welcome your reaction to this manual and hope that you will offer any consideration for how we can improve either subject matter or layout. Care Resources goal is to make this manual as helpful and easy to use as possible.

Please note that the existing provider contract may supersede some policies stated in this material.

If you have questions regarding the information contained within, please call your Provider Relations Liaison at 616-913-2006 (option #5) or 1-800-610-6299 (option #2)

Chapter

2

Service Procedures

The following procedures must be followed for all routine services provided to Care Resources participants. Care Resources must authorize all non-emergency services before services are rendered. Providers who render emergency services must notify Care Resources within 24 hours or on the next business day after that service has been rendered.

Referrals

1. Care Resources will contact the provider requesting the specific service. A referral form will be completed at that time and forwarded to the provider. This form will be received prior to the participants visit.

2. The scope of the services rendered is limited to those indicated on the referral form, and limited to the number of units identified. Any service not listed on the referral form, will not be reimbursed by Care Resources.

3. When providing specialty care, the specialist shall:

    a. Keep Care Resources informed of the participant's general condition with prompt verbal and/or written consult reports. Care Resources must receive a copy of all medical records concerning the participants care. Reports can be mailed to:

    Care Resources
    4150 Kalamazoo SE
    Grand Rapids, MI 49508
    Fax: 616-913-2003

    b. Obtain authorization from Care Resources for subsequent referrals for testing, hospitalization, or additional covered services.

c. Provide only those services authorized by Care Resources, with the exception of emergency care services.

d. Notify Care Resources, for prior authorization, when the participant requires the services of other specialist or ancillary providers for further diagnosis, specialized treatment, or if the participant requires admission to a hospital, rehabilitation facility, skilled nursing facility or an outpatient surgical facility.

Prescriptions

All prescriptions for Care Resources participants are to be filled through Kalamazoo Long Term Care pharmacy.

Kalamazoo Long Term Care Pharmacy Contact information is as follows:

Kalamazoo Long Term Care Pharmacy: 269-388-4850

Prescriptions cannot be filled at any pharmacy other than the Kalamazoo Long Term Care Pharmacy.

General Responsibilities of Contracted Providers

1. Medical Specialist - Provide on-call emergency and consultation services including arranging for backup coverage, twenty-four hours a day, seven days a week, three hundred sixty-five days a year. If there are members of your coverage group that do not participate with Care Resources, your practice must educate them on the Care Resources policies and procedures.

2. Provider shall not refuse to provide services to a participant based upon non-medical reasons, nor may Provider discriminate against any individual on the basis of race, color, gender, age, religion, national origin, disability, veteran's status, health status or need for health services.

3. Provider shall not engage in prohibited marketing activities such as:

    - discrimination of any kind among individuals who meet PACE eligibility standards
    - activities that could mislead or confuse potential participants or misrepresent Care Resources, CMS, or MDHHS
    - activities that involve gifts or payment to induce enrollment
    - contracting outreach efforts to individuals or organizations whose sole responsibility involves direct contact with the elderly to solicit enrollment, or unsolicited door –to-door marketing

4. Provider will submit medical or other pertinent information provided to Care Resources participants, as appropriate, and without violation of pertinent State and Federal laws regarding the confidentiality of medical records. Such information shall be provided without cost to Care Resources.

5. Provider will cooperate with Care Resources complaint and grievance procedures, which are incorporated herein by reference, and shall abide by the process.

Chapter

3

Inpatient Surgical/Medical Consultation

Because of the uniqueness of Care Resources, it has been helpful for us, and our specialist, to formalize some guidelines for inpatient consultation/care. These guidelines are outlined below, and may also be useful for other procedural consultations.

Purpose:

It is the purpose of this document to delineate some basic procedures that will help ensure patient centered care for our participants and will effectively utilize the resources of the Care Resources system and the expertise of our consultants. Further, recognizing that medicine is as much art as science and best answers are not always evident, guidelines are provided for resolving any disagreements that may arise.

Policy:

It is the policy of Care Resources to establish and maintain effective working relationships with our consultants, thereby promoting appropriate quality care for our participants. A few simple principles supply the foundation for consultative management of Care Resources participants and will be utilized to guide the management of care. These principles are as follows:

- Primary concern for participant's welfare
- Mutual respect
- Open communication
- Open-mindedness

Procedures:

Admission and consultation:

When Care Resources participants are hospitalized, they will be admitted by and to the Care Resources attending physician, and appropriate consultation will be obtained based

on the participants' condition. Every reasonable effort will be made to contact the consultant directly in an effort to establish and maintain effective communication.

Communicating with the family:

With the resources available to Care Resources for out-of-hospital management, we are generally able to discharge patients with enhanced outpatient support or to transitional care earlier than is typical, and we are able to do so without compromising their care. Because of this, it is important to discuss care in terms of types of services rather than length of stay. We ask our consultants to inform participants and their families that they will be working with the Care Resources physician(s) to determine when discharge is appropriate rather than providing information on typical lengths of stay for the participant's condition or procedure.

Surgery:

When surgical intervention is recommended, the consulting physician and Care Resources attending physician will discuss the risks and benefits and will agree on the proposed treatment plan. The surgeon will have primary responsibility for presenting the proposed intervention to the participant and family, obtaining informed consent, and answering their questions.

The Care Resources attending physician will coordinate all preoperative care and evaluation, obtaining any additional consultation that may be required.

During surgery and the immediate post-operative period (first 24 hours), the surgeon will be the attending physician with primary responsibility for management of the participant. This period may be lengthened or shortened based on circumstances and by mutual consent between the surgeon and the Care Resources physician.

Following the immediate post-operative period, the Care Resources physician will again assume primary responsibility for participant management with the advice and consultation of the surgeon related to management of the surgical condition. If there is concern that the surgical condition remains unstable, either physician may request additional consultation to clarify the appropriateness of this transfer of responsibility.

The surgeon and Care Resources physician will work together to delineate the care needs during the post-operative period. When Care Resources can effectively meet those needs in a non-hospital setting, discharge will be arranged. When the surgeon and Care Resources physician cannot agree on the appropriateness of discharge, the participant will be maintained at the higher level of care for an additional 24 hours during which time further evaluation, consultation, and/or mediation may be pursued to clarify the care needs and the suitability of the proposed environment.

Post hospitalization follow-up:

Communication is the key. Because of the close follow-up of Care Resources participants through the PACE Center with physician, nursing, rehabilitation evaluation, and treatment available five days a week, standard post-hospital follow-up is often not required. We request our consultants work with the Care Resources physicians to maximize the effectiveness of our PACE Center monitoring, including educating our physicians about special concerns or frequently encountered problems. At the same

time, Care Resources physicians will work to ensure that the consultant is aware of and has the opportunity to see and evaluate those problems directly related to the care they have provided.

Chapter 4

Billing Procedures

Invoices for services rendered to Care Resources participants must be submitted to Care Resources within 90 days. Institutional providers should use Form UB-04 to submit their charges; physicians use form HCFA 1500; and all other providers submit standard invoices. Claims are required to have accurate and specific ICD-10 diagnosis codes and CPT (including modifiers if applicable) procedure codes and/or HCPCS codes. To ensure timely payment (30 days), providers must inform their billing department that they must bill Care Resources directly and not Medicare, Medicaid, or the participant.

Filing a Paper Claim

Physicians

To be eligible for payment, all paper claims must be filed on a fully and accurately completed CMS 1500. The following fields on the CMS 1500 must be completed prior to submission:

- Patient Name
- Date of Birth
- ICD-10
- HCPCS codes
- Place of Service
- Provider Name
- Tax ID Number
- Date of Service
- Unit/Count Field
- CPT Procedure code(s)
- Modifier (if applicable)
- Total Charges
- Address/Phone Number
- NPI

Hospital/Facility

To be eligible for payment, inpatient and outpatient hospital claims must be submitted to Care Resources using a fully and accurately completed UB04 claim form. The following information must be included on the claim form:

- Hospital Name
- Tax ID Number/NPI
- Patient Name/Address
- Address/Phone Number
- Type of Bill
- Date of Birth

- Dates of Service
- Service Units
- Total Charges
- Revenue Code(s)
- CPT-4 Procedure Code(s) (if applicable)
- DRG code (if applicable)
- ICD-10 Diagnosis Code(s) (including any secondary diagnosis codes, coded to 5th digit)

All Other Types of Claims:

To be eligible for payment, services must be billed on a form that has been pre-approved by Care Resources. The following information must be included on the claim form:

- Patient Name/Address
- Dates of Service
- Description of Service
- Service Units
- Tax ID Number
- Date of Birth
- Billing code
- Total Charges
- Provider Name/Address/Phone Number

Submit claims to:

Care Resources Claim Department
C/O Reliance Community Care Partners
2100 Raybrook St SE, Ste 203
Grand Rapids MI 49546
616-913-2006, Option #4

Coordination of Benefits Billing Instructions

All claims must be submitted within ninety (90) days from the date of service to Care Resources. Care Resources will reimburse the provider of service according to the reimbursement rate in Attachment A of the provider contract.

If Care Resources determines there is a primary payer or a third party responsible for payment of the services, Care Resources will seek recovery from the primary or third party plan. No further action is needed by the Provider.

Please notify Care Resource if you believe there may be a third party liable for payment of services to a Care Resources participant.

Timely Filing Limits

Claims received more than 90 days from the date of service or as otherwise set forth within your provider contract will be denied, and the Care Resources participant may not be billed.

Balance Billing Patients

You are generally prohibited by the terms of your contract from billing Care Resources participants for any costs related to services you provide. For covered services, payment by Care Resources is considered payment in full.

You Must Not Balance Bill a Participant:

- For the difference between the charge amount and the Care Resources fee schedule.
- When a claim has been denied for late submission, unauthorized service, or as not medically necessary.
- When claims are pending review by Care Resources

Claim Appeals

In the event that Care Resources makes only partial payment or denies payment of a claim, Provider may appeal the decision by sending a letter marked "Appeal Request" to the Claims Department at Care Resources. Such letter shall contain the following information: Provider name, date of service, date of billing, date of partial or denied payment, participants name, and the reason(s) the claim merits reconsideration. The appeal must be submitted to Care Resources within sixty (60) days of the date of partial payment or denial. Care Resources will reject appeals submitted after the sixty (60) day limit.

Any questions regarding reimbursement should be directed to the Claims Department at Care Resources at 616-913-2006 (option #4), toll free at 1-800-610-6299, or can be emailed to claimsdept@careresources.org.

Chapter

5

Quality Assessment and Performance Improvement Program Outline and Procedures for Care Resources

The following describes the general procedures for Care Resources relationship with contract providers and the specific requirements for your contract.

Overview

Care Resources maintains overall responsibility for the quality of care delivered to its participants including services provided by contract providers. Care Resources is committed to the goal of providing the highest quality of care. This goal, which is shared with its contract providers, can only be attained through effective working relationships with contract providers as well as a comprehensive Quality Assessment and Performance Improvement Program (QAPIP). The following is a brief description of Care Resources' quality assessment and performance improvement program as related to contract providers. These are the specific quality assessment and performance improvement requirements that contract providers agree to fulfill.

Type of Contract Providers

The Care Resources Medical Director is responsible for monitoring and maintaining the quality of care provided by contract providers. Care Resources provides for the separation of medical services from fiscal and administrative management to assure that medical decisions are not unduly influenced. Care Resources maintains the following types of contractual arrangements:

- Contracts with Individual Providers, including physicians as well as health professionals who are not delegated responsibility for quality assurance activities.
- Contracts with Provider Organizations, including organized medical groups, hospitals, skilled nursing facilities, and ancillary service providers with established quality assurance programs.

Care Resources retains overall responsibility for the provision of quality care to its participants and as such establishes specific requirements for each type of

arrangement, which are delineated in the specific contract. In cases where providers have active quality assurance programs, Care Resources assesses the provider's ability to effectively perform quality assurance activities and, as appropriate, delegates specific requirements for quality assurance to the provider.

General Procedures

For all types of contract providers, the following procedures apply regarding periodic communication, implementation of corrective action plans and dispute resolution.

1. Credentialing- contracted Providers who provide services and care to our participants are required to provide the following information initially and updated as needed:
    a. Medicare/Medicaid Provider and National Provider Identification NPI Numbers
    b. Current Valid Professional License or Facility License as applicable
    c. Certificate of Accreditation (if applicable)
    d. W-9 IRS Form
    e. Proof of Worker's compensation insurance and Professional Liability insurance
    f. Have proof of the following for staff that have direct contact with participants
        a. Criminal clearances showing the person has not been convicted of any criminal offense which could jeopardize the health, safety, or well-being of any participant.
        b. Are oriented to Care Resources benefits and applicable procedures;
        c. Meet competency requirements where required for their duties.
2. Care Resources' Communication with Contract Providers
    a. Care Resources is responsible for timely communications with all contract providers with regards to quality assurance and performance improvement activities.
    b. Care Resources will ensure that all contract providers are involved in the development and implementation of quality assessment and performance improvement activities and are aware of the results of these activities.
    c. Significant changes or updates to Care Resources' QAPI Program will be sent to each provider.

d. The Care Resources Chief Operating Officer and other delegated staff that are members of the Interdisciplinary Team may serve as liaisons with contract providers.

e. The Care Resources Chief Operating Officer may communicate on a periodic basis with contract providers, by phone and in writing, to notify contract providers of policy changes, follow-up on complaints and incidents reported and ensure compliance with contract requirements.

f. On an annual basis, the Care Resources Medical Director reviews the QAPI program. Any significant changes will be reviewed and approved by the Quality Assurance Committee and the Care Resources Board of Directors. A description of those changes will be sent to each contract provider.

g. Feedback from contract providers should be directed to the Care Resources Medical Director or the Care Resources Chief Operating Officer who then informs the Care Resources Leadership Team.

3. Contract Provider Quality Assurance Responsibilities

Care Resources enters into contracts with providers for specific services outlined in their contract. These contracts delineate specific requirements for providers to adhere to Care Resources QAPI Program, grievance and appeals procedures and credentialing procedures as well as record keeping and other requirements related to assuring quality care. The quality of care delivered by these providers is evaluated as part of Care Resources QAPI program.

a. Any incident or unusual occurrence occurring at or in the contract provider's facility pertaining to Care Resources participants shall be communicated to the Center Manager by phone or in writing within 24 hours. The Center Manager discusses the incident with the Care Resources Medical Director to determine follow-up.

b. Each provider agrees to comply with Care Resources grievance and appeals procedures and abide by Care Resources adjudication process. On an ongoing basis, Care Resources primary care physician reviews timeliness and appropriateness of consultation reports and reports concerns to the Medical Director for follow-up.

c. Care Resources conducts on-site inspections, unannounced or scheduled, by the Care Resources Provider Relations Liaison, Care Resources Quality Director or assigned Care Resources staff to ascertain compliance with Care Resources QAPIP policies.

4. Implementation of Corrective Actions

The Care Resources Leadership Team is responsible for documenting that quality of participant care is reviewed, problems are identified and appropriate corrective actions are instituted. Problems or deficiencies in care may be uncovered during the course of routine or unscheduled

audits or reviews, interdisciplinary care planning, or may be raised through the grievance and appeals process. Each problem or deficiency will be addressed for serious problems, A Corrective Action Plan (CAP) will be instituted that is specific to the problem identified. The procedure is as follows:

a. The need for a Corrective Action Plan (CAP) will be determined by the Care Resources Medical Director and/or the Chief Operating Officer

b. The CAP must identify the parties, providers, facilities, programs, or operations that have fallen below the QAPIP standards.

c. The deficiency must be defined.

d. The Care Resources Medical Director or Chief Operating Officer contacts or meets with the parties involved to discuss the CAP.

e. The Care Resources Medical Director or Chief Operating Officer reports the deficiency and the CAP to the Quality Assurance Committee.

f. The Quality Assurance Committee reviews and approves the plan, indicating a time frame for compliance.

g. Follow-up audits may be conducted by the QAPIP staff or assigned staff to verify implementation of the CAP.

h. A summary of the findings is submitted to the Quality Assurance Committee on a quarterly basis.

i. All Corrective Action Plans are logged by the Quality Director.

j. All Corrective Action Plans will be forwarded to the Michigan Department of Health and Human Services.

5. Provider Dispute Resolution

Care Resources maintains procedures for resolving disputes between themselves and contract providers regarding administrative, operational, contractual or payment issues. The Care Resources Chief Operating Officer is responsible for processing disputes from contract providers.

6. Skilled Nursing Facilities (SNF)

Care Resources delegates some responsibilities for quality care review to SNF. The facilities must agree to comply with Care Resources QAPI program including the grievance and appeals procedures. Care Resources retains responsibility for investigating grievances regarding services rendered.

Care Resources primary care physicians are attending physicians for all participants residing in contracted SNF. Care Resources' primary care providers visits each participant in a SNF and other designated Care Resources Staff as deemed appropriate by the Interdisciplinary Team. Care Resources' physicians and staff report quality of care problems observed in the facility or identified in

reviewing participants' records to the Care Resources Medical Director or Chief Operating Officer for follow-up as part of the grievance process.

Each contracted SNF is responsible for reporting to the Care Resources Medical Director within 24 hours for the following systemic problems that may impact the quality of care provided to Care Resources participants. Such problems include:

a. Outbreak of infectious disease reportable to the Kent County Health Department
b. Strike involving health care personnel.
c. Licensing or certification contingency.
d. Changes in key staff positions, including Administrator, Facility Physician and Director of Nursing.

Chapter

6

Participant Rights

Participant Rights in Care Resources PACE

When participants join Care Resources PACE, they have certain rights and protections. Contracted providers are expected to respect and abide by the following participant rights:

1) You have the right to be treated with respect.

You have the right to be treated with dignity and respect at all times, to have all of your care kept private, and to get compassionate, considerate care. You have the right:

- To get all of your health care in a safe, clean environment and in an accessible manner.
- To be free from harm. This includes excessive medication, physical or mental abuse, neglect, physical punishment, being placed by yourself against your will, and any physical or chemical restraint that is used on you for discipline or convenience of staff and that you do not need to treat your medical symptoms or to prevent injury.
- To be encouraged to use your rights in Care Resources PACE program.
- To get help, if you need it, to use the Medicare and Medicaid complaint and appeal processes, and your civil and other legal rights.
- To be encouraged and helped in talking to Care Resources staff about changes in policy and services you think should be made.
- To the reasonable use of a telephone while at the Day Center.
- To not have to do work or services for Care Resources PACE program.

2) You have a right to protection against discrimination.

Discrimination is against the law. Every company or agency that works with Medicare and Medicaid must obey the law. They cannot discriminate against you because of your:

- Race, ethnicity, or national origin
- Religion
- Sexual Orientation
- Age
- Sex
- Mental or physical disability
- Source of payment for your health care (For example, Medicare or Medicaid)

If you think you have been discriminated against for any of these reasons, contact a staff member at Care Resources to help you resolve your problem.

If you have any questions, you can call the Office for Civil Rights at 1-800-368-1019.

TTY users should call 1-800-537-7697.

3) You have a right to information and assistance.

You have the right to get accurate, easy-to-understand information and to have someone help you make informed health care decisions. You have the right:

- To have someone help you if you have a language or communication barrier so you can understand all information given to you.
- To have Care Resources PACE program interpret the information into your preferred language in a culturally competent manner, if your first language is not English and you can't speak English well enough to understand the information being given to you.
- To get marketing materials and PACE participant rights in English and in any other frequently used language in your community. You can also get these materials in Braille, if necessary.
- To have the enrollment agreement fully explained to you in a manner understood by you.

- To get a written copy of your rights from the Care Resources PACE program. The PACE program must also post these rights in a public place in the Day Center where it is easy to see them.
- To be fully informed, in writing, of the services offered by the Care Resources PACE program. This includes telling you which services are provided by contractors instead of the PACE staff. You must be given this information before you join, at the time you join, and when you need to make a choice about what services to receive.
- To be provided with a copy of individuals who provide care-related services not provided directly by Care Resources upon request.
- To look at, or get help to look at, the results of the most recent review of the Care Resources PACE program. Federal and State agencies review all PACE organizations. You also have a right to review how Care Resources plans to correct any problems that are found at inspection.

4) You have a right to a choice of providers.

You have the right to choose a health care provider within the Care Resources PACE program's network and to get quality health care. Women have the right to get services from a qualified women's health care specialist for routine or preventive women's health care services.

You have the right to have reasonable and timely access to specialists as indicated by your health condition.

You also have the right to receive care across all care settings, up to and including placement in a long-term care facility when Care Resources can no longer maintain you safely in the community.

5) You have a right to access emergency services.

You have the right to get emergency services when and where you need them without the Care Resources PACE program's approval. A medical emergency is when you think your health is in serious danger – when every second counts. You may have a bad injury, sudden illness or an illness quickly getting much worse. You can get emergency care anywhere in the United States and you do not need to get permission from Care Resources prior to seeking emergency services.

6) You have a right to participate in treatment decisions.

You have the right to fully participate in all decisions related to your health care. If you cannot fully participate in your treatment decisions or you want to have someone you trust help you, you have the right to choose that person to act on your behalf. You have the right:

- To have all treatment options explained to you in a language you understand, be fully informed of your health status and how well you are doing, and to make health care decisions. This includes the right not to get treatment or take medications. If you choose not to get treatment, you must be told how this will affect your health.

- To have the Care Resources PACE program help you create an advance directive, if you choose. An advance directive is a written document that says how you want medical decisions to be made in case you cannot speak for yourself. You should give it to the person who will carry out your instructions and make health care decisions for you.

- To participate in making and carrying out your plan of care. You can ask for your plan of care to be reviewed at any time.

- To be given advance notice, in writing, of any plan to move you to another treatment setting and the reason you are being moved.

7) You have a right to have your health information kept private.

You have the right to talk with health care providers in private and to have your personal health care information kept private and confidential, including health data that is collected and kept electronically, as protected under State and Federal laws.

You have the right to look at and receive copies of your medical records and request amendments.

You have the right to be assured that your written consent will be obtained for release of information to persons not otherwise authorized under law to receive it.

You have the right to provide written consent that limits the degree of information and the persons to whom the information may be given.

There is a patient privacy rule that gives you more access to your own medical records and more control over how your personal health information is used. If you have any questions about this privacy rule, call the Office for Civil Rights at 1-800-368-1019. TTY users should call 1-800-537-7697.

8) You have a right to file a complaint, request additional services or make an appeal.

You have a right to complain about the services you receive or that you need and don't receive, the quality of your care, or any other concerns or problems you have with the Care Resources PACE program. You have the right to a fair and timely process for resolving concerns with the Care Resources PACE program. You have the right:

• To a full explanation of the complaint process.

• To be encouraged and helped to freely explain your complaints to the Care Resources staff and outside representatives of your choice. You must not be harmed in any way for telling someone your concerns. This includes being punished, threatened, or discriminated against.

To contact 1-800-MEDICARE for information and assistance, including to make a complaint related to the quality of care and the delivery of a service.

You have the right to request services from Care Resources that you believe are necessary. You have the right to a comprehensive and timely process for determining whether those services should be provided.

You also have the right to appeal any denial of a service or treatment decision by the Care Resources PACE program, staff, or contractors.

9) You have a right to leave the program.

If, for any reason, you do not feel that the Care Resources PACE program is what you want, you have the right to leave the program at any time and have such disenrollment be effective the first day of the month following the date Care Resources receives the participants' notice of voluntary disenrollment.

Additional Help

If you have complaints about the Care Resources PACE program, think your rights have been violated, or want to talk with someone outside your PACE program about your concerns, call 1-800-MEDICARE or 1-800-633-4227 to get the name and phone number of someone in your State Administering Agency.

You can also contact the MI Choice and PACE Ombudsman Program for help or more information. The staff can talk with you about how to make an appeal and what to expect during the appeal process. The MI Choice and PACE Ombudsman is an independent program and the services are free. Call 1-888-746-6456 (TTY: 711). The MI Choice and PACE Ombudsman is available Monday through Friday, 9:00am to 5:00pm.

Chapter

7

Grievance Procedure for Care Resources Participants

Policy

A written record of all grievances and resolutions shall be maintained and reviewed at least quarterly by the Senior Leadership Team, Quality Director, Quality Committee, and through minutes, by the Governing Body. The Quality Director will maintain, aggregate and analyze this information in order to promote continuous quality improvement.

Participants have the right to voice their concerns, free of any restraint, interference, coercion, discrimination or reprisal by the Care Resources staff.

Grievances are kept confidential. When a grievance is made, the administration will keep the complaint private, to the extent possible. The Director of Quality and/or Center Manager will decide who needs to be notified of the grievance. Confidentiality of the grievance is adhered to as outlined in the Privacy/ Confidentiality Policy.

All staff reviews the Care Resources Policy Privacy / Confidentiality policy at the time of their orientation and sign a confidentiality acknowledgement form. Confidentiality is part of the annual mandatory in-service training and violations of the policy will result in disciplinary action. Contracted providers will be held accountable to all grievance procedures established by Care Resources. Care Resources will monitor providers' compliance with this requirement. The grievance process and applicable procedures will be reviewed both verbally and in writing with the participant/family/designated representative by the designated staff member at the time of enrollment and annually. Beneficiary notification will include the availability of assistance with completing a grievance. The grievance policy and procedure will be made available upon request to the participant/family members/designated representative.

Purpose

Participants of Care Resources PACE, who have a concern or complaint about their quality of care or service delivery, have access to the established Grievance process. Participants can file a formal grievance either verbally or in writing.

Procedure

Filing a Grievance

1. A grievance may be expressed either verbally or in writing to the participant's Social Worker, or the Day Center Manager. If assistance in filing a grievance is needed, the participant's Social Worker will provide this service.

2. Upon receipt of a grievance, the Care Resources Center Manager will discuss with and provide to the participant in writing, the specific steps, including the timeframe for response that will be necessary to resolve the grievance.

3. If the participant/family member/designated representative wishes to file a grievance during non-center hours, the administrator on call will be responsible for receiving and then communicating the grievance to the Care Resources Center Manager the next business day.

Documentation of Grievances

1. A Grievance Log will be maintained in a confidential location. Every grievance expressed, either verbally or in writing will be documented on the Grievance Log on the day it was received. If a grievance was received after hours, it will be documented the next business day on the Grievance Log.

2. It is the responsibility of the Center Manager to ensure documentation and follow up on the grievance.

Resolution

1. Notification of the receipt of the grievance will be mailed to the participant or designated representative within seven business days of receipt. It is the responsibility of the Center Manager to investigate and seek resolution of the grievance within thirty (30) business days from the date it was received.

2. Care Resources will continue to furnish all required services to the participant during the Grievance Process.

3. The Center Manager will investigate the problem, determine the best method to solve the problem and take the necessary steps needed to settle the matter, including meeting with parties involved when necessary, or taking the matter up with the Senior Leadership Team.

4. Once the grievance response has been determined, the participant/family member/designated representative will receive from the Center Manager, a written copy of the proposed resolution. Included in the letter will be further steps that can be taken if the participant/family member/designated representative is not satisfied with such resolution.

Dissatisfaction

1. Any participant/family member/designated representative who is dissatisfied with the outcome of the grievance resolution can take further action by contacting the Care Resources Chief Operating Officer within thirty (30) days of the proposed resolution.

2. All efforts will be made by the Care Resources Chief Operating Officer to resolve the ongoing grievance and inform the participant of the final proposed resolution within thirty (30) days.

Data Collection and Reporting

1. The Quality Director is responsible for maintaining, aggregating and analyzing information related to grievances.

2. All grievances will be reviewed quarterly by the Senior Leadership Team, Quality Assurance Committee, and through minutes, the Governing Body at their routine meetings.

3. Trends and patterns will be identified by the Quality Director and reported quarterly to the Senior Leadership Team and the Quality Committee with development of action plans for any negative trends.

4. Grievance information is included in the quarterly CMS HPMS data collection and the MDHHS utilization Report.

Compliance and Enforcement:

All management personnel are responsible for enforcing this policy. All employees and contract providers must comply with this policy. Employees or contract providers who violate this policy are subject to discipline up to and including termination from Care Resources.

Chapter

8

Appeals Procedure for Care Resources PACE Participants

Policy

The Medicaid participant may request an external appeal at any time during the Appeals Process. The Medicare only participant must follow the internal appeals process first.

All requests for an appeal will be treated in a confidential manner, in compliance with Care Resources Confidentiality/Privacy Policy. All staff reviews the Confidentiality /Privacy at the time of their orientation and sign a confidentiality acknowledgement form. Confidentiality is part of the annual mandatory in-service and violations of the policy will result in disciplinary action. Contracted providers will be held accountable to appeals procedures established by Care Resources. Care Resources will monitor providers' compliance with this requirement on an annual basis.

The appeal process and applicable procedures will be reviewed both orally and in writing with the participant/family/representative by the designated staff member at the time of enrollment, annually and when Care Resources denies, reduces or terminates services, or when Care Resources denies payment for services. Beneficiary notification will include the availability of assistance with completing an appeal. Such notification will be in writing for denial of coverage or payment. The appeal process and procedure will be made available upon request to the participant/family member/representative.

Procedure

1. An appeal may be expressed either verbally or in writing to the participant's Social Worker, the Center Manager, Quality Director or Chief Operating Officer.

2. An appeal should be filed within thirty (30) days of the written denial of services, notification of non-payment, termination or reduction in services.

3. Upon receipt of an appeal, the Care Resources Center Manager, Quality Director or Chief Operating Officer will discuss with and provide in writing, the specific steps, including the time frame for response that will be necessary to resolve the appeal.

4. If the participant/family member/designated representative wishes to file an appeal during non-center hours, the administrator on-call will be responsible for receiving and then communicating the appeal to the Center Manager, Quality Director or Chief Operating Officer the next business day.

5. All requests to appeal a decision will be documented by the Quality Director in an appeal log and maintained in a confidential location.

6. Non-expedited requests will be resolved as expeditiously as the participant's health requires, but no later than thirty (30) calendar days after receipt of the appeal.

Expedited Appeals

If there is the belief of the participant/family member/designated representative that his/her life, health or ability to regain maximum function would be seriously jeopardized without the services in question being provided, then the participant/family member/designated representative can request an expedited appeal. If the participant/family member/designated representative does not request an expedited appeal, the Quality Director will determine if the appeal requires and expedited review process.

In the case of an expedited appeal, the Center Manager will:

a. Immediately contact the necessary Interdisciplinary Team members for
discussion and review of the recent assessment or request. Only those persons directly involved with resolving the concern will be notified.

b. Care Resources must respond to the expedited appeal as expeditiously as the participant's health requires, but not to exceed seventy-two (72) hours after Care Resources receives the appeal. Care Resources may extend the 72-hour timeframe by up to 14 calendar days for either of the following reasons:

The participant requests the extension
Or
Care Resources justifies to MDHHS (Michigan Department of Health and Human Services) the need for additional information and how the delay is in the interest of the participant.

7. During the appeals process, Care Resources will meet the following requirements:

   a. Continue to furnish the disputed service until issuance of the final determination if the participant acknowledges that he/she may be liable for the costs of the contested services if the determination is not made in his/her favor.

   b. There shall be no discrimination against a participant on the grounds that he/she has filed an appeal.

8. The service in question will be reviewed for appropriateness taking into consideration the medical, social, and functional needs of the participant.

9. A Third party appropriately credentialed and not involved in the original decision and having no stake in the outcome will review the participant's appeal. The third party may include but are not limited to community physicians, or others as may be appropriate.

10. For a determination in favor of a participant, Care Resources will advise the participant and furnish the disputed service as expeditiously as the participant's health condition requires.

11. If Care Resources determines that the decision regarding the appeal cannot be reversed, the participant's file will be forwarded to the Centers for CMS Medicare and Medicaid Services and the Michigan Department of Health and Human Services, Administrative Tribunal.

12. Regarding determinations that are averse to the participant either wholly or in part, Care Resources will notify the participant in writing of his/her appeal rights under Medicare or Medicaid, or both, and should the participant elect to appeal, Care Resources shall assist the participant in choosing which to pursue (if both are applicable), and forward the appeal to the appropriate external entity.

External Appeals

1. An appeal may be made to Medicare or Medicaid, but not both. The social work department will assist the participant with the process chosen. An external appeal must be requested in writing.

2. A Medicaid participant may make an external appeal, at any time. Information can be obtained by calling or writing:

   Administrative Tribunal
   Michigan Department of Health and Human Services

PO Box 30763
Lansing, MI 48909
(877) 833-0870

3. If the participant chooses the Medicare Appeals Process, the participant must complete the Care Resources internal process first, before Care Resources forwards the appeal externally to the Center for Health Dispute Resolution.

4. The participant may appeal to the MDHHS Administrative Tribunal at any time during the appeal process.

Data Collection and Reporting

1. A written record of all appeals shall be maintained by the Quality Director, including the initial date, identification of the appeal, the date of resolution and a summary of the resolution itself.

2. The Quality Director will maintain, aggregate and analyze information on the appeal proceedings. Data is reviewed quarterly for trends and presented to the Quality Committee. The Quality Director will forward the information to the Senior Leadership Team. The Quality Director will share the information with the Care Resources Participant Advisory Committee (PAC), and through minutes, the Governing Body at their routine meetings. Committee members are alerted to trends and patterns that will be incorporated as a formal part of the Care Resources Quality Assessment and Performance Improvement Plan.

Appeal information is included in the quarterly CMS HPMS data collection and the MDHHS Utilization Report.

Compliance and Enforcement

All management personnel are responsible for enforcing this policy. All employees and contract providers must comply with this policy. Employees or contract providers who violate this policy are subject to discipline up to and including termination from Care Resources.

Chapter

9

Definitions

Appeal: a formal complaint process involving the Participant's health care services including denial of services or non payment of services

Care Resources: The name of the Program of All-inclusive Care for the Elderly (PACE). Care Resources covers the full spectrum of health, rehabilitative, and social services required by frail elderly persons: primary medical care, medical specialty care, adult day health care, home health services, in-home support services, acute hospital care, physical and occupational rehabilitation, psychiatric facilities, and custodial nursing home care.

Care Resources Medical Director: The Care Resources Medical Director is responsible for the implementation and oversight of the QAPI Program and reports directly to the Board of Directors. The Care Resources Medical Director confers and collaborates with the Care Resources Chief Operating Officer on all matters related to the operations of Care Resources. For administrative purposes only, the Care Resources Medical Director reports to the Chief Operating Officer. The Care Resources Medical Director oversees the implementation; evaluation, supervision, maintenance and reporting of program compliance and achievements related to Care Resources' quality of health care as well as maintain responsibility for the Care Resources QAPIP staff.

Care Resources Chief Operating Officer: The Care Resources Chief Operating Officer is responsible for Care Resources operations, including managing contracts with service providers, ensuring administrative compliance with licenses, and acting as a liaison with regulatory agencies. The Care Resources Chief Operating Officer is a member of both the Quality Assessment and Performance Improvement Committee and Care Resources, Management Team and participates in the on-going review and revision of the QAPI Program.

Care Resources Quality Director: The Care Resources Quality Director reports to the Care Resources Medical Director. The Quality Director is responsible for implementation, monitoring, supervision and evaluation of the QAPI Program.

Care Resources Senior Leadership Team. The Care Resources Senior Leadership Team provides oversight for the administrative and clinical operations of the organization. The Senior Leadership Team may create new committees or task forces to improve and or focus on specific clinical or administrative processes that have been identified as critical to participants, families and staff. The Senior Leadership team will review all QAPI program initiatives and reports; provide oversight for proposed changes to improve quality of services, and review follow up of all CMS implemented changes.

Emergency Medical Condition – An *Emergency Medical Condition* is defined as: a medical condition manifesting itself by acute conditions of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of medical attention to result in the following: (1) serious jeopardy to your health; (2) serious impairment to bodily function; or (3) serious dysfunction of any bodily organ or part.

Grievance: a complaint, either written or verbal, expressing dissatisfaction with service delivery or the quality of care furnished.

Health Care Services: Health care services are services such as medical care, diagnostic tests, medical equipment, appliances, drugs, prosthetic and orthotic devices, nutritional counseling, nursing, social services, therapies, dentistry, optometry, podiatry, audiology, etc. Health Care Services may be provided in the Care Resources Day Center, in the participant's home, in the offices of specially trained people, in hospitals, or nursing homes that have agreements with Care Resources to give health care services to Care Resources participants.

Interdisciplinary Team- Interdisciplinary Team is the Care Resources interdisciplinary professional team made up of; a physician, mid-level providers, social worker, registered nurse, pharmacist, Center Manager, home care coordinator, physical therapist, recreations therapist, occupational therapist, speech therapist, dietician, transportation coordinator, and personal care attendants. The Interdisciplinary Team will review medical, functional and psychosocial conditions to develop a Plan of Care. From time to time, the Interdisciplinary Team will meet to talk about a participant's needs, decide if needs have changed, and to change a participants Plan of Care to meet these needs.

Lock-in Provision: The Lock-in Provision means the source of non-emergency services are limited to Care Resources, or to sources pre-approved by Care Resources.

Long Term Care: Long-Term Care means continuous services to manage chronic diseases.

Participant: A Participant is anyone who is eligible and has signed the Enrollment Agreement to receive health care services from Care Resources

Participant Advisory Committee: The Participant Advisory Committee (PAC) is the advisory body that represents the interest of the participants, caregivers, and the community. The PAC provides a mechanism for participants and consumers to provide recommendations and feedback to Care Resources. The PAC meets at least quarterly.

Service Area: Care Resources Service Area is Kent County and specific zip code areas in Allegan, Barry, Ionia, or Ottawa County in the State of Michigan.

Quality Committee: The Quality Committee has responsibility for developing the QAPIP annual plan, guiding the implementation of quality activities and involving the staff in the QAPIP process through education and input. The following positions will be represented; Chief Operating Officer, Medical Director, Quality Director, cross representation from all areas of disciplines of the interdisciplinary team and other representative as necessary. Assessing the continuity and effectiveness of the QAPI Program, providing guidance on recommendations for improvement as needed and reporting findings and recommendations to the Care Resources Board of Directors.

Chapter

10

Contact Information

Address

Care Resources PACE
4150 Kalamazoo Ave SE
Grand Rapids, MI 49508

Important Phone Numbers

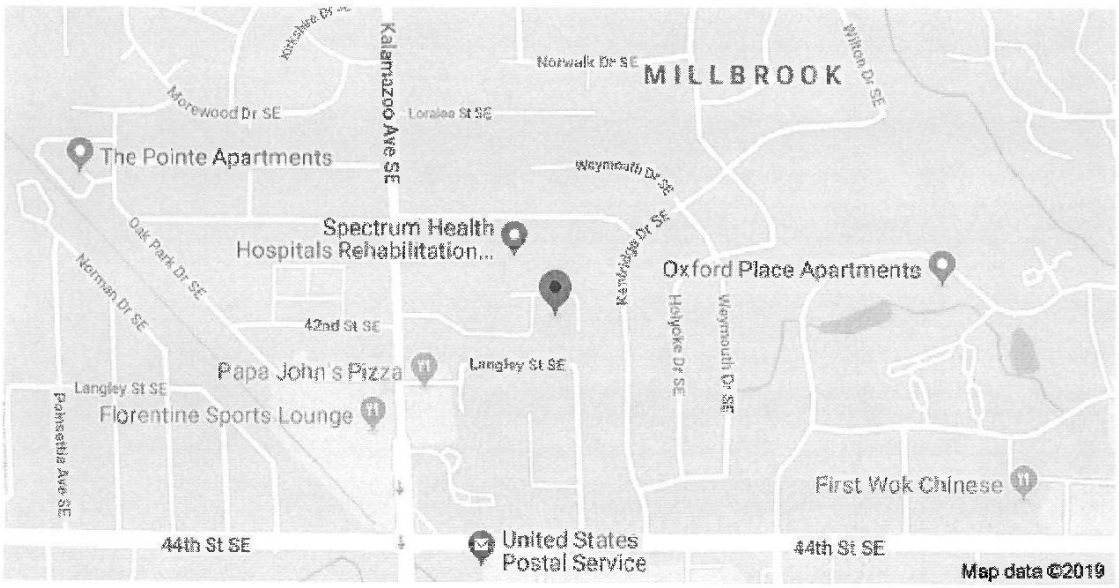
Main	616-913-2006
Toll Free	800-610-6299
Fax	616-913-2005
Chief Operating Officer	616-913-2014
Center Manager	616-913-2014
Medical Director	616-913-3088
Transportation Supervisor	616-913-2001
Home Care Supervisor	616-913-2004
Quality Director	616-913-2012
Claims Department	866-479-5050
Pharmacy	616-913-2032
Clinic- authorizations	616-913-3099

Website

www.careresources.org

Providers may currently access general information about Care Resources.

Location Map



Chapter

11

Care Resources Membership Card

CARE RESOURCES MEMBERSHIP CARD

4150 Kalamazoo Ave SE
Grand Rapids, MI 49508
616-913-2006
1-800-610-6299

care resources PACE

Program of All-Inclusive Care for the Elderly

Name: Sample Participant
Contract #: 00000000
Effective Date: 10/1/2019

All services must be prior authorized and billed through CARE RESOURCES

Failure to contact CARE RESOURCES prior to the provision of non-emergency services will result in forfeiture of billing rights for all unauthorized services.

If the patient is presenting in an emergency room, please contact CARE RESOURCES immediately at **(616) 913-2006.**

FOR AUTHORIZATION OF SERVICES:
CALL (616) 913-2006.

SUBMIT CLAIMS TO: RelianceCCP
2100 Raybrook St SE, Ste 203
Grand Rapids, MI 49546

For Claim Inquiries Call:
(616) 913-2006 Option #4

Sample Confirmation of Service Form

4150 Kalamazoo Ave SE
Grand Rapids, MI 49508
ph. 616.913.2006 800.610.6299
fax. 913.2005
www.care-resources.org

Service Authorization

9/23/19
Approved Service Provider:
SPECTRUM KALAMAZOO ST REHAB/NURS
4118 KALAMAZOO SE
GRAND RAPIDS MI 49508-3605

Member: **MRN: 000157427**
Date of Birth:
Group #: CAR501-CARE RESOURCES PACE PROGRAM
Referral Authorization Number: 2524386
Authorized Services

Auth Type	OT OTHER SERVICES
Service Class	0190
Service Description	SUBACUTE CARE IN A HOSPITAL OR NURSING FACILITY [10468075]
Authorized Units	3
Authorized Unit Type	Day
Frequency	1
Interval	Daily
Start Date	9/21/2019
End Date	9/23/2019
Place of Service	31 SKILLED NURSING FACILITY
COMMENTS	RUG rate

This Referral is limited to the services and number of visits/units that have been prior authorized. All services must be provided at the above listed frequency and interval. The inability to provide the contracted service must be reported immediately to Care Resources. All requests for additional services are required to be prior authorized by Care Resources. Failure to obtain prior authorization for non-emergency services will result in payment denial. Balance billing the member under this health plan is prohibited by Federal Regulations.

Claims should be submitted to:
Reliance Community Care Partners
2100 Raybrook St. SE, Ste. 203
Grand Rapids, MI 49546
For questions call: (616) 913-2006

Chapter

12

Requirements for Services in the Home and Out-of Home Respite

The following standards and definitions apply to each contracted service provider interested in providing the particular service to Care Resources participants. Each contracted provider must adhere to the service definitions and minimum standards to be eligible to receive reimbursement of allowable expense.

Care Resources
Minimum Standards & Definitions

SERVICE NAME	Personal Care Attendant
SERVICE DEFINITION	Personal Care includes assistance with eating, bathing, dressing, personal hygiene, and activities of daily living. This service may include assistance with preparation of meals, but does not include the cost of the meals themselves. When specified in the plan of care, this service may also include such housekeeping chores as bed making, dusting and vacuuming, which are incidental to the care furnished, or which are essential to the health and welfare of the individual, rather than the individual's family. This service also includes supervising the care of the participant by reminding, prompting, cueing, and frequently directing the activities of daily living. Personal care attendants must have been trained in the PACE program.
SERVICE HCPCS CODE	T1019 Home health aide or certified nurse assistant, provider care in the home
UNIT OF SERVICE	Per 15 minute unit

Minimum Standards

1. Annual updated employee training checklist listing all staff employees, who are providing services to Care Resources participants, with the following areas of competency evaluated by a licensed Registered Nurse to include, but are not limited to:
    a. See Non Certified/Certified Personal Care Attendant competency checklist.

2. Criminal background checks and Medicare/Medicaid exclusion checks must be conducted on all employees providing care to Care Resources participants by the contracted provider.

3. Staff who meet the minimum training requirements established by the State of Michigan for contracting providers under Medicaid.

4. Staff who meet a minimum of twelve (12) hours of relevant in-service training per calendar year as required by The State of Michigan.

5. Adherence to the established plan of care developed by the Interdisciplinary Team. This includes adherence to the time, length, and frequency of visits and reporting to appropriate Care Resources staff any critical information involving the needs of Care Resources participants.

6. Meeting, at all time, the authorized needs of Care Resources participants. Should an individual employee not be able to fulfill the assignment, it is expected that the providers notify the Care Resources Home Care Coordinator immediately.

7. Assigning consistent staff to specific Care Resources participants whenever possible in order to improve continuity of care and assure strong communication between the team and the provider.

8. Each contracted provider that chooses to allow staff to assist participants with self-medication shall establish written procedures that govern the assistance given by staff to Care Resources participants with self-medication. The provider staff authorized to assist participants with taking their own prescription or over-the-counter medications and under what conditions such assistance may take place. Authorized provider staff may only remind, cue, or hand the participant their preset medication minder. This must include a review of the type of medication the participant takes and its impact upon the participant. Personal care workers may not administer medications.

Consistent failure to meet the authorized Plan of Care for Care Resources participants may result in termination of the Contractual relationship.

Care Resources
Minimum Standards & Definitions

SERVICE NAME	Homemaking
SERVICE DEFINITION	Services consisting of the performance of general household tasks, (e.g., meal preparation, routine household cleaning and maintenance, laundry) provided by a qualified homemaker. This service also includes observing and reporting any change in the participant's condition and the home environment to the Home Care Coordinator. **This service <u>may not</u> provide any Personal Care, such bathing, dressing and personal hygiene.**
SERVICE HCPCS CODE	S5130
UNIT OF SERVICE	15 minutes

<u>Minimum Standards</u>

1. Individuals employed as homemakers must have previous relevant experience or training and skills in housekeeping, household management, observation reporting, and recording information, as well as a minimum of 1 year experience working with frail or elderly. Additionally, skill, knowledge, and/or experience with food preparation, safe food handling procedures, and reporting and identifying abuse and neglect are highly desirable.
2. Annual updated employee training checklist listing all staff employees, who are providing services to Care Resources participant, with the following areas of competency evaluated by a Supervisor to include, but are not limited to:
    a. Observation, reporting, and documentation of participant status and the services rendered.
    b. Maintenance of a clean, safe, and healthy environment.
    c. Change Linen
    d. Laundry
    e. Housecleaning skills- Clean participants area
    f. Maintaining confidentiality
    g. Meal Preparation
    h. Universal Precaution/Infection Control
    i. Recognizing emergencies and knowledge of emergency procedures.
3. Required bi-annual in-service training topics shall include, but are not limited to sanitation, household management, nutrition, and meal preparation.
4. Criminal background checks must be conducted on all employees providing care to Care Resources participants by the contracted provider
5. Adherence to the established plan of care developed by the Interdisciplinary Team. This includes adherence to the time, length, and frequency of visits and reporting to appropriate Care Resources staff any critical information involving the needs of Care Resources participants.
6. Meeting, at all time, the authorized needs of Care Resources participants. Should an individual employee not be able to fulfill the assignment, it is expected that the providers notify the Care Resources Home Care Coordinator immediately.
7. Assigning consistent staff to specific Care Resources participants whenever possible in order to improve continuity of care and assure strong communication between the team and the provider.

Consistent failure to meet the authorized Plan of Care for Care Resources participants may result in termination of the contractual relationship.

Care Resources PACE Program
PRIORITY CLASSIFICATION SYSTEM

Care Resources Pace Program staff will establish for each participant, a priority classification ranking that will classify the need for delivery of services at exact times and on exact day/dates as authorized by the program staff. The Staff will communicate the participant's priority ranking to each provider at the time of the service referral/arrangement. This classification may also be found on the Confirmation of Services (COS). The priority ranking will be subject to Care Resources review and possible revision on an on-going basis.

This classification ranking will assist the provider in planning for unforeseen circumstances that may interfere with delivery of services. Unforeseen circumstances may include inclement weather emergencies, disaster conditions, transportation failures, illness of staff affecting service provision to the participant, etc. The following sections detail the criteria and structure the providers options in scheduling accordingly.

PARTICIPANT PRIORITY CLASSIFICATION	SERVICE PRIORITY
Priority Status I If service is not delivered as authorized, the participant's health and welfare would be at immediate risk. Criteria for classification include one or more of the following: • Terminal illness • Dementia • Bedfast or non-ambulatory without assistance • No capable or willing informal caregiver • Diabetic requiring meal preparation • Incontinence • Skin Lesions	**Priority Status I** Priority I participants must receive delivery of service as authorized by Care Resources Staff, irrespective of unforeseen staffing circumstances. Priority I participants shall receive preference over Priority III participants for delivery of services as authorized.
Priority Status II If service is not delivered as ordered, the participant's health and welfare would be at risk. Criteria for the classification include one or more of the following: • Wheelchair bound requiring only partial assistance with transfers • Ambulatory but intermittently confused • Lives alone and has an inconsistent or unstable support system • Informal caregiver works during time of service delivery • Informal caregiver at risk and needs relief	**Priority Status II** Priority II participants shall receive preference over Priority III participants for the delivery of services when staffing emergencies interfere with providing services to both participants at the same time.
Priority Status III If service is not delivered as ordered, the participant's health and welfare could be at risk. Criteria for this classification include one or more of the following: • Can partially meet own needs • Has a responsive informal support system, even if living alone, that could be mobilized on a short term basis • Caregiver needs relief, but could provide care • Lives in an AFC, Home for the Aged or Assisted Living	**Priority Status III** Priority III participants shall receive services in the amount and frequency authorized, but may have the time of day or week altered to assure service delivery to a Priority I or II participants in the event of unforeseen circumstances resulting in a staffing emergency.

GENERAL PRINCIPLES OF USING THE PRIORITY CLASSIFICATION SYSTEM

1. The provider is responsible for assuring that all participants receive services as authorized by Care Resources Staff. The priority classification system should not be used as a replacement for sound staffing planning in the acceptance of Care Resources referrals.

2. The provider must notify the participant(s)who is to receive a new caregiver, or a change in service appointment, of the change prior to implementing the change.

3. The provider must report the change in service appointment times to the Care Resources Home Care Coordinator. When disruption of service is to extend beyond one day, the provider must notify the Home Care Coordinator of the participant(s) affected, the reason why the service order is disrupted, and how subsequent service orders will be affected.

4. The provider should not change the participants time or date of service without prior authorization from the Care Resources Home Care Coordinator.

5. At no time should this classification be used by the provider to alter weekly service units in order to serve another participant. The authorized units of service should be performed as ordered unless an unforeseen circumstance occurs. If services are disrupted, the Care Resources Home Care Coordinator should be notified as soon as possible.

Care Resources
Minimum Standards & Definitions

SERVICE NAME	Respite Care provided outside of the home
SERVICE DEFINITION	Services provided to individuals unable to care for themselves; furnished on a short-term basis because of the absence or need for relief of those persons normally providing the care.
SERVICE HCPCS CODE	H0045, Respite services not in the home, per diem
UNIT OF SERVICE	Per day

Minimum Standards

8. Each out of home respite service provider must be either a Medicaid certified hospital or a licensed group home as define in MCL 400.701 ff, which includes adult foster care homes and homes for the aged.

9. The eligibility criteria includes, at a minimum:
    a. Participants must require continual supervision to live in their own homes or the home of a primary caregiver, or require a substitute caregiver while their primary caregiver needs relief or is otherwise unavailable, and
    b. Participants have difficulty performing or are unable to perform activities of daily living without assistance.

10. Respite services include:
    a. Attendant care (participant is not bed-bound) such as companionship, supervision and/or assistance with toileting, eating, and ambulation; and,
    b. Basic Care (participant may or may not be bed bound) such as assistance with ADL's, a routine exercise regimen, and self medication.

11. The contracted provider must obtain information from the Care Resources Home Care Coordinator describing the respite care support services the participant needs.

12. All workers must be trained and knowledgeable about the Care Resources PACE program.

13. Each contracted provider shall demonstrate a working relationship with Care Resources contracted hospitals and/or other health care facility for the provision of emergency health care services, as needed. With the assistance of the participant and/or participant's caregiver, Care Resources shall determine an emergency notification plan for each participant.

14. Each contracted provider shall establish written procedures to govern the assistance given by staff to participants with self-medications. These procedures shall be reviewed by a consulting pharmacist, physician, or registered nurse and shall include, at a minimum:
    a. The provider staff authorized to assist participants in taking either prescription or over-the-counter medications and under what conditions such assistance may take place. This must include a review of the type of medication the participant takes and it's impact upon the participant.
    b. Verification of prescription medication and their dosages. The provider shall maintain all medication in original, labeled containers.
    c. Instructions for entering medication information in participant files.

15. Each contracted provider shall employ a professionally qualified provider director that directly supervises provider staff. Personnel assignments must conform to the wage and hour provisions of pertinent local, state, and federals laws.

Care Resources
Minimum Standards & Definitions

SERVICE NAME	Personal Emergency Response System
SERVICE DEFINITION	PERS is an electronic device which enable certain individuals at high risk of institutionalization to secure help in an emergency. The individual may also wear a portable "help" button to allow mobility. The system is connected to the person's phone and programmed to signal a response center once a "help" button is activated. The response center is staffed by trained professionals.
SERVICE HCPCS CODE	S5160 Emergency Response System; installation and testing S5161 Emergency response system; service fee, per month
UNIT OF SERVICE	S5160, per installation S5161, per month

Minimum Standards

1. The Federal Communication Commission must approve the equipment used for he response system. The equipment must meet UL® safety standards 1637 specifications for Home Health Signaling Equipment.
2. The provider must staff the response center with trained personnel 24 hours per day, 365 days per year. The response center will provide accommodations for persons with limited English proficiency.
3. The response center must maintain the monitoring capacity to respond to all incoming emergency signals
4. The response center must have the ability to accept multiple signals simultaneously. The response center must not disconnect calls for a return call or put in a first call, first serve basis.
5. The provider will verify the responder and contact names for each participant on a semi-annual basis to assure current and continued participation.
6. The provider will assure at least monthly testing of each PERS unit to assure continued functioning.
7. The provider will maintain individual participant records that include the following:
    a. Service Order
    b. Record of service delivery, including documentation of delivery and installation of equipment, participant/caregiver orientation, and monthly testing,
    c. List of emergency responders for each participant, and
    d. A case log documenting participant and responder contacts.