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INFO 05-25-03

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MEMORANDUM FOR HOME AND COMMUNITY BASED SERVICES STAFF AND STAKEHOLDERS

FROM: Erica Keller, Bureau Chief
Bureau of Systems and Data Reporting

SUBJECT: HCBS Fusion Updates

This memorandum serves to provide Home and Community Based Services (HCBS) staff and stakeholders with information and guidance following the recent release of the new electronic case management system, Fusion. With all transitions, come opportunities for improvement. The Division of Senior and Disability Services (DSDS) is working hard to ensure any defects or enhancement needs are met timely. DSDS recognizes many of these items are important to your day-to-day work and will work to address them during monthly enhancement releases beginning in June. Please see the information below to help guide transitional actions.

Provider Dashboard & Notifications

Notifications

The provider notification emails have been temporarily disabled due to a known defect. The goal of the notifications is to notify the provider of a care plan change and provide a direct link to the new or updated care plan authorization. In the interim, DSDS staff will resume previous processes and inform the provider via email or phone of the updated care plan.

Dashboard

At this time, each provider's dashboard displays all active participants with the provider agency. DSDS recognizes additional enhancement is needed to discern which participants have been newly modified, closed, or added. DSDS recognizes the challenges this presents and will be prioritizing this in upcoming releases.

Care Plans

Prior Authorizations

All care plans were migrated from Web Tool to Fusion. There have been no impacts to the prior authorizations sent from Web Tool to MMIS and no billing issues are anticipated.

Care Plan View

At this time, the printable care plan view is not displaying certain service type headers but does display all tasks authorized. This is known defect DSDS will work to correct.

Monthly Unit Authorizations

Fusion's care plan calculation method accounts for the number of days in each month. Monthly unit maximums will fluctuate based on the number of days in a month. Migrated care plans will only show the total units based on the longest month scenario (Ex: 31 days for a day care plan). Once a participant's care plan is updated Fusion (annual reassessment or care plan change), Fusion will display prorated units-based number of days in a month.

Residential Care Facility/Assisted Living Facility Care Plans

As mentioned above, migrated care plans will not display the prorated monthly units. RCF/ALFs that prefer this authorization detail will have until June 30th to access and download care plans from Web Tool. Again, once the care plan is reauthorized in Fusion, this information will be available in Fusion.

Medicaid Eligibility

Providers may use Fusion to check Medicaid eligibility for any individual currently receiving HCBS through DSDS by viewing the MMIS Info tab on a participant record. Providers will not be able to use Fusion to check Medicaid eligibility for those newly seeking HCBS. DSDS is working to update this in future releases. In the interim, Providers should use EMOMED to determine if the participant has the correct Medicaid status before submitting a referral.

General Health Evaluations

Any participant with ongoing authorized nurse visits will not have General Health Evaluations (GHEs) migrated in Fusion. In Web Tool, this information was added as a note in the Service Delivery Comments box and this information could not be migrated. Providers should determine the date the most recent assessment was completed and calculate the 4th and 10th month following that date to determine which months GHEs should be delivered alongside the other nurse visit task. A chart to assist with calculating the 4th and 10th months is available in HCBS Policy 3.15. Once a participant's care plan is updated at the annual reassessment, GHEs will display on the care plan.

Note: Participants with no authorized nurse tasks and only GHEs will have information displaying the authorization months on the migrated care plan.

Online Requests and Referrals

Providers submitting online referrals or change requests may check the status by utilizing the 'Referral' and 'PCCP Request' tabs. No information will display under these tabs until initial review is completed by HCBS Intake or the PCCP team. Typically, this review occurs within 2-3 business days of receipt however wait times are increased as DSDS transitions to Fusion. Please allow at least two weeks before calling to check on the status of a referral or change request. If the referral or PCCP request is determined as appropriate by Intake or PCCP, information will display under the applicable tab showing it has been processed. The information will further update when assigned to a DSDS team member for action.

In the event the referral or request was inappropriate, no information will display. DSDS recommends reviewing your submission before calling to ensure all information submitted was accurate or the information has not changed since submission. Common inappropriate reasons include Medicaid status

issues (i.e. wrong type of Medicaid, inactive Medicaid, no Medicaid), submission to the wrong portal (i.e. should have been a care plan change request and sent as a referral or vice versa) or name and DCN do not align. Please also remember to check to see if a participant has active services before submitting a referral. If they have active services, any requests need to be submitted as a PCCP request.

DSDS is appreciative of all the feedback and support received through this transition. We continue to work hard to ensure all users have access and support during the transition. Please see INFO 05-25-02 for the help line opportunities.

Questions regarding this memorandum should be directed to the Bureau of Systems and Data Reporting via e-mail at HCBS.Systems@health.mo.gov.

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