

Patient Liability

For Medicaid Nursing Facility (NF) Providers

Provided By: Bureau of TennCare Division of
Long-Term Services & Supports (LTSS) &
TennCare Managed Care Organizations (MCOs)

May 2013

Resources

Resource Documents:

- Memo Issued 9/9/2011: Important Information regarding Patient Liability and Item D Deductions
- Memo Issued 5/3/2013: Additional Guidance Regarding Collection of Monthly Patient Liability
- Patient Liability Guide for Nursing Facility Services

Overview

For Today's Training:

Patient Liability:

- A **monthly** amount that persons receiving Medicaid LTSS (NF or HCBS) or hospice services in a NF are required to contribute to the cost of their care (based on income)
- Also used to offset the **Medicaid** payment for **Medicare** services in a SNF for dual eligible members who are **not** Qualified Medicare Beneficiaries (QMBs)
 - For QMBs, the Medicaid payment for Medicare services cannot be reduced based on the member's patient liability obligation (if any)

Not Rest & Relaxation for today

Roles and Responsibilities:

- **Department of Human Services (DHS):** determines patient liability obligation
- **Nursing Facility:** collects each Medicaid resident's patient liability
- **Managed Care Organization:** reduces the monthly Medicaid payment to a NF (or to a hospice agency for hospice room and board in a NF) by the entire amount of patient liability due for that month

Managed Care Organizations:

- Apply patient liability similar to an insurance deductible, except on a monthly basis.
- Apply the entire monthly patient liability obligation to the first payable NF claim received by the MCO (*will explain further...*).
- Apply any remaining patient liability balance to the next NF claim received and processed by the MCO for that member.
- Apply patient liability *only* up to the cost of Medicaid payments for Medicaid NF, Medicare SNF or hospice room and board in a NF provided during that month.

Review

Again:

- MCOs are obligated to deduct the **entire monthly** patient liability amount from the Medicaid payment for Medicaid NF or hospice room and board claims, so long as that amount does not exceed Medicaid payments for LTSS or hospice room and board provided during that month; with the *only exception* being the month of enrollment/disenrollment into CHOICES (*more to come about month of enrollment/disenrollment*)...

Memo Issued 9/9/2011: Important Information regarding Patient Liability and Item D Deductions:

If a person is absent from the facility and there is a non-covered day, (because the person has exhausted his bed hold days or the facility does not meet minimum occupancy requirements to bill bed hold days)...

- the facility must still collect the full monthly patient liability amount
- and the total Medicaid payments made by the MCO for the month must still be reduced by the total monthly patient liability amount...

so long as the total patient liability collections do not exceed total Medicaid payments for NF services, Medicare SNF services, or hospice room and board for the month.

Exceptions

Exception to the Rule:

- As stated, the total Medicaid payments made by an MCO for services (including hospice) in a NF during a month must be reduced by the total **monthly** patient liability amount...
- *With the exception of:*
 - I. the month of enrollment into and disenrollment from CHOICES Group 1*; *or*
 - II. the month of election/withdrawal of election of hospice services in a NF; **and**
 - III. only in instances when, for some part of the month, the person was neither enrolled in CHOICES Group 1 nor receiving hospice services in a NF.

* *The TennCare MMIS is the system of record for CHOICES enrollment.*

Hospice

Election to receive hospice in a NF:

- When a Medicaid eligible member elects to receive hospice services in a NF:
 - he is not enrolled into CHOICES Group 1.
 - if enrolled in CHOICES 1 at the time of hospice election, is disenrolled from CHOICES 1.
- Such member remains obligated to pay his patient liability obligation to offset the Medicaid payment for hospice room and board in the facility.

Election to receive hospice in a NF:

- What does this mean?
 - Tom enrolls in CHOICES Group 1 April 1st and then disenrolls April 20th in order to elect to receive hospice in the NF for the rest of the month. What are Tom's patient liability obligations?
 - He is obligated to pay his full monthly patient liability amount unless for some part of the month he was neither enrolled in CHOICES Group 1 nor receiving hospice services in the NF.
 - This remains the same if Tom is receiving hospice in a NF at the beginning of the month and withdraws his hospice election during the month and then enrolls into CHOICES Group 1 for receipt of NF services. *However...*

Neither

Neither Hospice or CHOICES Group 1:

- Monthly patient liability amount is pro-rated based on the total number of days he is enrolled in CHOICES Group 1 and the total number of days he is receiving hospice services in the NF during the month.
- This is primarily to allow the person sufficient income to pay community living expenses for the remainder of the month when neither NF nor hospice services in a NF are received.
- Applied regardless of the reason for disenrollment or withdrawal of election of hospice services in a NF, including when a resident is deceased.

Hospice

How will this work? Paying for CHOICES NF claims:

- When someone enrolled in CHOICES Group 1 elects to receive hospice services in the NF, he/she must be disenrolled from CHOICES Group 1.
- NFs must complete and submit to the MCO in a timely manner the Discharge/Transfer/Hospice Form (found on LTSS website, LTSS Partners, LTSS Forms).
- The MCO will notify TennCare when a member is no longer receiving NF services to disenroll the member from CHOICES Group 1.
- TennCare will process the disenrollment and send updated CHOICES eligibility/enrollment information to the MCO.
- Once the updated CHOICES enrollment information is received, the MCO will pro-rate the member's patient liability for the month, based on the number of days the member was enrolled in CHOICES.

Hospice

How will this work? Paying for hospice claims:

- The NF invoices the hospice agency for the room and board rate (95% of the NF's per diem).
- The NF's invoice must show a credit for the patient liability the NF is responsible for collecting (pro-rated based on the number of days of hospice services received during that month) .
- The hospice agency pays the NF the 95% per diem rate minus the facility's pro-rated patient liability obligation.
- The hospice agency submits a claim to the MCO reflecting the 95% per diem rate for hospice room and board minus the facility's pro-rated patient liability obligation.
- The MCO's payment to the hospice agency is 95% of the facility's per diem rate for hospice room and board minus the facility's pro-rated patient liability obligation.

Enrollment

Let's Review Two Examples

Related to Month of Enrollment/Disenrollment from CHOICES Group 1

Enrollment

Example 1 (Resident A)

- Tom enrolls in CHOICES Group 1: 4/16 (PL=\$2,000)
 - Total number of days enrolled in Group 1 for April = 15 days
 - PL pro-rated $\$2,000 \times 15 / 30$ days in April = \$1,000
 - NF's Medicaid per diem rate = $\$150 \times 15$ days = \$2,250
 - NF Charges \$2,250 – Tom's pro-rated PL amount \$1,000 =
Balance of \$1,250 paid by MCO (subject to timely filing requirements)

Enrollment

Example 1 continued

- Tom is discharged to the hospital and will return to the facility (or to another NF)
 - He is **not** disenrolled from CHOICES Group 1
 - The monthly patient liability amount should **not** be pro-rated
 - The facility may be eligible to bill bed hold days (see TennCare Rule 1200-13-01-.03(9)). If not, the days he was hospitalized will be non-covered days, and may be billed accordingly. However, this does **not** reduce the amount of his **monthly** patient liability obligation for Medicaid covered services.

Enrollment

Example 2 (Resident B)

- Jerry has been enrolled in CHOICES several months (PL=\$2,000)
 - 4/1 Jerry is admitted to the hospital (1st admission for the year)= 15 days
 - 4/16 Jerry returns to NF for rest of month (4/16-4/30)
 - Jerry's monthly patient liability amount will not be pro-rated b/c he has remained enrolled in CHOICES Group 1 the entire month.
- During Jerry's hospital stay, at least 85% of all other beds in the facility were occupied.
 - The NF can bill for 10 bed hold days of the 15 hospital days (had not utilized any of Jerry's 10 bed hold days for the year).

Enrollment

Example 2 continued

- NF's Medicaid per diem rate = $\$150 \times [15 \text{ days} + 10 \text{ days (bed hold)}] = \$3,750$
 - NF Charges $\$3,750$ – Jerry's PL amount $\$2,000$ (full month)=
Balance of $\$1,750$ paid by MCO (subject to timely filing requirements)

**If the full amount of a resident's monthly patient liability amount has been collected and the resident subsequently discharges from the facility and disenrolls from CHOICES Group 1, the facility must pro-rate the former resident's monthly patient liability amount based on the number of days he was enrolled in CHOICES Group 1 during that month, and promptly return any overpayment to the resident.*

Transitions

Transitions to Group 2 or 3

- When a resident transitions to CHOICES Group 2 or 3 and begins receiving HCBS, he is disenrolled from CHOICES Group 1.
- The monthly patient liability amount collected by the facility is pro-rated based on the number of days the person was enrolled in CHOICES Group 1 during that month.
- Upon discharge, collection of patient liability for HCBS is the responsibility of the MCO, based on a community personal needs allowance that takes into account the income necessary to pay community living expenses.

Transitions

Example (Resident C)

- Mary has been enrolled in CHOICES Group 1 for several months and is transitioning into the community with CHOICES Group 2 (NF PL=\$2,000). Transitions on 4/16.
 - Total number of days enrolled in Group 1 for April = 15 days
 - PL pro-rated $\$2,000 \times 15 / 30$ days in April = \$1,000
 - NF's Medicaid per diem rate = $\$150 \times 15$ days = \$2,250
 - NF Charges $\$2,250 - \text{Mary's pro-rated PL amount } \$1,000 =$
Balance of \$1,250 paid by MCO (subject to timely filing requirements)

**Mary's patient liability amount in the community will be re-calculated by DHS based on the community personal needs allowance. Mary's MCO will be responsible for patient liability collections for HCBS once she is transitioned to the community.*

Transfers

Transfers between Medicaid NFs

- When a resident transfers between Medicaid NFs during a month, the facility where the resident first resided is responsible for collection of the total monthly amount of patient liability up to the cost of Medicaid services provided by that facility during that month.
- The facility to which the resident transfers is responsible only for collection of any remaining patient liability amount up to the cost of Medicaid services provided by the second facility.
- Medicaid NF receiving transfer is responsible for obtaining as part of the transfer, information regarding the resident's monthly patient liability obligation and collections for the month.
- NF claims are processed by the MCOs on a first-in/first-out basis.
 - The transferring NF should submit claims promptly; if submitted *after* the receiving facility's claims have been processed, will require notification to the MCO and manual adjudication.

Let's Review Two Examples

Related to Month of Transfers between Medicaid NFs

Transfers

Example 1 (Resident D)

- Jane has been enrolled in CHOICES Group 1 for several months in NF1 and is transferring to NF2 closer to her family (NF PL=\$2,000). Transfers on 4/16.
 - Total number of days enrolled in Group 1 for April = 15 days
 - NF's Medicaid per diem rate = \$150 x 15 days = \$2,250
 - Jane's cost of Medicaid services (\$2,250) in NF1 is at least as much as her monthly PL amount (\$2,000)
 - NF1 will collect full monthly amount of PL.
 - NF2 will not collect any PL for remainder of April, but will be responsible for PL collections beginning in May.

Example 1 continued

- If the full amount of a Jane's monthly patient liability amount has been collected by NF1 and she subsequently transfers to NF2, and the cost of Medicaid services provided by NF1 is less than the monthly amount of patient liability collected (less than \$2,000), NF1 must promptly return any overpayment to Jane for services provided in that facility.
 - NF2 will be responsible for patient liability collections for Medicaid services it provides during the remainder of April, and for subsequent months.

Transfers

Example 2 (Resident E)

- Bob has been enrolled in CHOICES Group 1 for several months in NF1 and is transferring to NF2 closer to his family (NF PL=\$2,000). Transfers on 4/16.
 - Total number of days enrolled in Group 1 for April = 15 days
 - NF's Medicaid per diem rate = \$100 x 15 days = \$1,500
 - Bob's cost of Medicaid services (\$1,500) in NF1 is less than his monthly PL amount (\$2,000)
 - NF1 will collect PL for the full cost of NF services provided (\$1,500).
 - NF2 will collect remainder of PL (\$500) to offset the cost of Medicaid NF services provided by NF2 for remainder of month.

Crossovers

Patient Liability Collection for Residents Receiving Medicare SNF Services During the Month

- In Tennessee (as in many states), the crossover claims reimbursement methodology for Medicare Skilled NF (SNF) services limits the Medicaid payment based on the Level 2 per diem rate established for that facility. **If the Medicare rate is higher than the Medicaid Level 2 payment for NF services, the Medicaid crossover payment amount is zero.**
- 42 CFR § 447.21 prohibits the facility from collecting patient liability if it exceeds the allowed amount deemed by Medicaid and provides for sanctions in the event the facility does so.
 - **If Medicaid owes nothing on the SNF crossover claim, then patient liability cannot be collected by the facility for the claim.**

Crossovers

Patient Liability Collection for Residents Receiving Medicare SNF Services During the Month

- In the rare circumstance that the Medicaid Level 2 per diem rate exceeds the Medicare rate for the SNF services, a pro-rated portion of the monthly patient liability amount may be collected by TennCare (based on the number of days of SNF services provided) to offset the Medicaid cost sharing payment for Medicare SNF services, unless the person is a Qualified Medicare Beneficiary (QMB).
- **This amount is limited by the Medicaid payment obligation.**

Crossovers

For now:

- **The facility must...**
 - notify MCO of previous SNF stay and patient liability collection for the crossover payment
 - work with the MCO to ensure collections are appropriately accounted for in the application of patient liability for the Medicaid NF services

Coming soon:

- **TennCare will...**
 - complete systems changes that will bypass patient liability collections on SNF crossover claims when the person is enrolled in CHOICES Group 1 during that month
 - notify you when this has been completed

Crossovers

Let's Review Four Examples

Related to

Patient Liability Collection for Residents Receiving
Medicare SNF Services During the Month

Crossovers

Example 1 (Resident F)

- Joe has been receiving Medicare SNF services following an acute hospitalization. He is a non-QMB dual eligible member. He is not yet enrolled in CHOICES Group 1.
 - Joe's Medicare (SNF services) per diem rate = \$300
 - His Level 2 Medicaid per diem rate = \$200
 - What's higher? *Medicare*...this means the crossover payment for Medicare SNF service = \$0...and PL cannot be used to offset the cost of Medicare SNF services.

Crossovers

Example 1 continued

- Note: Again, this relates to Medicaid payments for Medicare SNF services...
 - This does **not** impact his patient liability obligations for Medicaid NF services or Medicaid payments for hospice services in a NF that may also be provided during the month.
 - Collection of PL for Medicaid NF services or Medicaid payments for hospice services in a NF remains in effect.
 - The facility is not entitled to keep any of the patient liability collected for payment of the SNF claim, and in fact, if it does so, is in violation of federal law and subject to sanctions.

To the extent that Medicaid payments made by the MCO do not fully account for the monthly patient liability amount and the facility is overpaid, as previously advised, the facility may also be in violation of the State and Federal False Claims Acts and subject to overpayment provisions as specified in Section 6402 of the Affordable Care Act.

Crossovers

Example 2 (Resident G)

- Vicki has been receiving Medicare SNF services following an acute hospitalization. She is a non-QMB dual eligible member. She is not yet enrolled in CHOICES Group 1.
 - Vicki's Medicare (SNF services) per diem rate = \$300
 - Her Level 2 Medicaid per diem rate = \$200
 - What's higher? *Medicare*...this means the crossover payment for Medicare SNF service = \$0...and PL cannot be used to offset the cost of Medicare SNF services.

Crossovers

Example 2 continued

- Following her Medicare SNF stay, Vicki is enrolled into CHOICES Group 1 for receipt of Medicaid NF services. Her date of enrollment into CHOICES Group 1 is 4/16. (NF PL=\$2,000). Transfers on 4/16.
 - PL pro-rated $\$2,000 \times 15$ (days enrolled in Group 1)
/ 30 days in April = \$1,000
 - NF's Medicaid per diem rate = $\$200 \times 15$ days = \$3,000
 - NF Charges \$3,000 – Vicki's pro-rated PL amount \$1,000 =
Balance of \$2,000 paid by MCO (subject to timely filing requirements)

Crossovers

Example 3 (Resident H)

- Ann has been receiving Medicare SNF services following an acute hospitalization. She is a non-QMB dual eligible member.
 - Ann's monthly patient liability = \$2,000
 - Her Medicare (SNF services) per diem rate = \$200
 - Her Level 2 Medicaid per diem rate = \$210
 - What's higher? *Level 2 Medicaid*...this means the crossover payment for Medicare SNF service = Difference of the two amounts (\$10 per day)...

Crossovers

Example 3 continued

- A pro-rated portion of her monthly PL amount will be used to offset the cost of Medicare SNF services provided Ann up to the Medicaid payment obligation = \$10 of her monthly PL amount
- This will be accounted for in the processing of the crossover claim by TennCare.
- The facility cannot collect any amount which exceeds the Medicaid payment obligation for purposes of Medicare cost sharing.

Crossovers

Example 3 continued

- Ann enrolls into CHOICES Group 1 on 4/16
 - PL pro-rated $\$2,000 \times 15$ (days enrolled in Group 1)
/ 30 days in April = $\$1,000$
 - Qualifies to receive Medicaid Level 2 = $\$210 \times 15$ days = $\$3,150$
 - NF Charges $\$3,150$ – Ann's pro-rated PL amount $\$1,000$ =
Balance of $\$2,150$ paid by MCO (subject to timely filing requirements)

* If instead, the resident was already enrolled in CHOICES Group 1 at the beginning of the month and then subsequently was hospitalized and received Medicare SNF services (while remaining enrolled in CHOICES Group 1), then the entire monthly patient liability amount, up to the cost of Medicaid NF services provided, must be collected and used to offset the cost of Medicaid NF services provided.

Crossovers

Example 4 (Resident J)

- George has been enrolled in CHOICES Group 1 for several months. On April 1st, he is admitted to the hospital and subsequently returns to the facility for 10 days of Medicare SNF services, after which he resumes Medicaid NF services on April 16th, with Level 2 Medicaid reimbursement. He is a non-QMB dual eligible member.
 - George's monthly patient liability = \$2,000
 - His Medicare (SNF services) per diem rate = \$200
 - His Level 2 Medicaid per diem rate = \$210
 - What's higher? *Level 2 Medicaid*...this means the crossover payment for Medicare SNF service = Difference of the two amounts (\$10 per day)...

Crossovers

Example 4 continued

- George has remained enrolled in CHOICES Group 1 the entire month of April...this means his monthly PL amount will **not** be pro-rated based on the numbers of days he receives Medicaid NF services.
- Medicaid charges \$3,150 – [\$2,000 monthly PL - \$100 from crossover payment (or \$1,900)] = Balance of \$1,250 paid by MCO (subject to timely filing requirements)...

Crossovers

Example 4 continued

- A pro-rated portion of his monthly PL amount will be used to offset the cost of Medicare SNF services provided George up to the Medicaid payment obligation = \$10 of his monthly PL amount
- Medicaid payment obligation = $\$10 \times 10$ days (Medicare SNF services) = \$100
- This will be accounted for in the processing of the crossover claim by TennCare

More Examples

**Let's review more
Patient Liability Claim Examples**
(Grid provided: Appendix A of Patient Liability Guide)

Billing/Recovery

- Any payments made by an MCO for NF services or hospice R&B for which **all** required monthly patient liability amounts were not deducted (and/or patient liability amounts retained by the facility) constitute an overpayment of Medicaid funds.
 - ACA Section 6402 provides 60 days from discovery to return overpayments and avoid additional liability under State/Federal False Claims Acts.
- MCOs are expected to review claims with dates of service January 2012 forward and reprocess claims as necessary.
- The State's federally mandated Recovery Audit Contractor will review claims with dates of service Sept 2011 through Dec 2011 in accordance with this guidance.
 - RAC review of NF claims for dates of service *prior to* September 2011 will **not** recover based on pro-rated application of patient liability for covered days of NF services, but will recover other patient liability related overpayments.

Billing/Recovery

Managed Care Organizations: Billing Procedures

Billing Requirements

- Revenue Codes 0183, 0185 and 0191 must be billed with Type of Bill 066x.
- Revenue Code 0192 must be billed with Type of Bill 021x.
- Revenue Codes 0189 and 0224 may be filed with either Type of Bill 066x or 021x.
- An Occurrence Code of 54 must be filed along with the last date of a physician follow-up visit on all NF Level 1 and Level 2 claims.
- An approved authorization is required for Enhanced Level 2 services. The claims must be billed with the appropriate Revenue Code/Procedure Code/Modifier Code combination for the services provided:
 - Revenue Code 0192 / Procedure Code 94004: Chronic Ventilator Care
 - Revenue Code 0192 / Procedure Code 94004 / Modifier Code 22: Vent Weaning
 - Revenue Code 0192 / Procedure Code 94004 / Modifier Code 52: Tracheal Suctioning
- Revenue Code 0224 is used to bill for the date of death if the member passes away after 12:00 noon.
- Dates of service must be within the same month and providers are encouraged to bill full month at a time.
- Line item dates of service must correspond with the Statement Dates.

Amerigroup Overpayment Recovery Process

- **June 3, 2013 – Amerigroup sends Overpayment Notification Letters to impacted Nursing Facilities**
- **June 3 – July 8 – Each Nursing Facility may specify repayment preference**
 - **Provider prefers to submit check**
 - **Provider prefers recovery to be taken from future claims**
 - **Specific Amerigroup contact information and instruction provided on overpayment notification letter**
- **July 8, 2013 - Follow-up letter sent to non-responsive Nursing Facilities**
- **August 9, 2013 – Final notice sent to non-responsive Nursing Facilities advising recovery from future claims will begin on September 16, 2013**



Recovery Process



- Letters will go out June - August
- Letter mailed to NF – will detail the claim and recovery amount
- Letter will request payment back to UHC within 45 days
- Recovery Services can establish a payment plan for larger amounts where NF operations may be impacted
- NF should contact their Provider Advocate if they have any questions or contact Deborah Stewart, Director of LTSS Network Programs, at deborah_b_stewart@uhc.com



ATTN: Recovery Services
 PO Box 740804
 Atlanta, GA 30374-0804
 Phone: 1-800-727-6735
 Fax: 1-248-733-6019

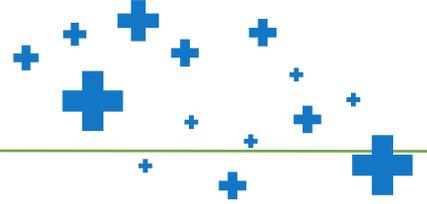
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 <<PrvAdd2>>
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Refund Request Detail for TIN: <<ProviderTIN>>

Claim UID	Patient Name	Patient Acct #	Overpaid Audit #	First DOS	Last DOS	Date Paid	Amount Paid	Pymt Check #	Amount Overpaid	Overpymt Balance
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Provider Name:										
Notes: Historical Audit Number: <<Historical Audit Number>> Amount Enclosed: _____										

Claim UID	Patient Name	Patient Acct #	Overpaid Audit #	First DOS	Last DOS	Date Paid	Amount Paid	Pymt Check #	Amount Overpaid	Overpymt Balance
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Provider Name:										
Notes: Historical Audit Number: <<Historical Audit Number>> Amount Enclosed: _____										



Patient Liability Recoveries

- BlueCare Tennessee will soon begin an outreach effort to notify providers of overpayments related to the application of the members' Patient Liability Amount (PLA). All recoveries must be completed by 12/31/2013.
- Overpayments are usually deducted from the facilities' remittance advice; however, recovery options will be discussed as needed during the outreach effort.
- Call BlueCare Tennessee Provider Service for assistance at 1-800-468-9736 for BlueCare or 1-800-276-1978 for TennCareSelect, Monday through Friday 8 a.m. to 6 p.m., ET.
- More information about overpayment processing may be found in the BlueCare Tennessee Provider Administration Manual at bluecare.bcbst.com.



Health Plans
BlueCare™ East and West
TennCareSelect
SelectKids
SelectCommunity
CHOICES
What is CHOICES
How to Apply for CHOICES
CHOICES Groups
Abuse, Neglect or Exploitation

CHOICES



Wrap Up

Do you have other scenarios related to patient liability collection not covered in these materials?

If Yes, what to do:

Email scenarios to **Darrell Winningham**, Director of Reimbursement, Tennessee Health Care Association dwinningham@thca.org by Friday 5/31.

Here's what we will do:

Compile additional scenarios and send out to all NFs. Amend the *Guide* to include these examples, as appropriate, and post on the LTSS website.

Questions?