

# Community HealthChoices

O V E R V I E W

Community HealthChoices  
Southwest Provider Summit

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Department of Human Services



pennsylvania  
DEPARTMENT OF HUMAN SERVICES

# Network Adequacy

## ARE THERE NATIONAL MLTSS STANDARDS?

- National MLTSS network adequacy standards aren't available.
- The Department has been working with consumers to help develop standards.
- The Department is gathering information to establish a baseline of the number of full time equivalents (FTEs) that are potentially needed to continue to provide services and meet the needs of the participants.
- The CHC-MCOs are asking providers for this information during a provider's initial enrollment with an MCO and on an ongoing basis.
- DHS will re-evaluate network adequacy at the end of the 180 day continuity of care period to ensure consumers have access to LTSS.
- The commonwealth will conduct ongoing monitoring to ensure the MCOs maintain provider networks that enable participants choice of provider for needed services.

# CONTINUITY OF CARE

- CHC-MCOs are required to contract with all willing and qualified existing LTSS providers of all types for 180 days after CHC implementation.
- Participants may keep their existing HCBS providers, including service coordinators, for the 180-day continuity of care period after CHC implementation.
- A participant whose resides in a nursing facility on the implementation date will be able to stay in their nursing facility as long as they need this level of care, unless they choose to move.

# PROCESS TO BEGIN CHC ELIGIBILITY AND SERVICE PROVISION

## COUNTY ASSISTANCE OFFICE

- Determines financial eligibility
- No change to eligibility criteria or eligibility process

## INDEPENDENT ENROLLMENT BROKER

- Receives notification from DHS of new CHC participant
- Collects information from participant
- Sends an alert to Aging Well to complete Functional Eligibility Determination (FED)

## AGING WELL

- Completes the FED
- FED software algorithm will determine whether the participant is Nursing Facility Clinically Eligible (NFCE) or Nursing Facility Ineligible (NFI)

## CHC-MCO

- Receive data from the FED
- Completes the comprehensive needs assessment
- Must use assessment results in developing Person-Centered Service Plan

# PROCESS FOR ELIGIBILITY AND SERVICE REDETERMINATION

## COUNTY ASSISTANCE OFFICE

- Determines financial eligibility
- No change to eligibility criteria or eligibility process

## INDEPENDENT ENROLLMENT BROKER

- Receives notification from DHS of ongoing CHC eligibility

## CHC-MCO

- Completes the redetermination using InterRAI HC tool.
- InterRAI HC tool generates an NFCE or NFI designation and transmit results to Aging Well
- Updates the Person-Centered Service Plan

## AGING WELL

- Validates the annual redetermination process was completed by CHC-MCO and conducted correctly



# Providers

# PREPARING FOR CHC

## WHAT SHOULD MY ORGANIZATION DO?

- Contact CHC-MCOs to discuss contracting. Each MCO's contact information is included on slide 14.
- Participate in CHC Third Thursday webinars to learn more about CHC.
- Participate in stakeholder engagements.
- Read and share within your organization any CHC-related information sent to you by the Department.
- Participate in upcoming educational sessions hosted by the Department.

# PROVIDER ENROLLMENT

## HOW DO PROVIDERS ENROLL WITH A CHC-MCO?

- All CHC-MCO providers must be enrolled with Medicaid and must be credentialed by and contracted with a CHC-MCO to receive reimbursement for a CHC participant.
  - The Medicaid enrollment process verifies a provider meets Medicaid enrollment requirements.
  - Providers must be enrolled in Medicaid for all types of services they wish to provide under CHC.
  - To meet necessary accreditation standards, CHC-MCOs must go through a similar process. This process has additional requirements related to the approval process, time limits for how long information can be used in verifying providers, and requires direct verification of provider information.
- Provider must agree to contractual terms and meet CHC-MCO participation requirements.
  - The CHC-MCOs will determine best practices and quality standards to support their programs.
- CHC-MCOs are currently actively contracting with providers in the Southwest region.
  - Providers are encouraged to engage with the CHC-MCOs now to assure continuity of care for participants.
  - After the continuity of care period, service coordination entities must contact CHC-MCOs to discuss subcontract arrangements.



# PROVIDER ENROLLMENT

## DO SUBCONTRACTORS TO SERVICE COORDINATION ENTITIES NEED TO TAKE ANY SPECIAL ACTIONS?

- All CHC-MCO providers must be enrolled in Medicaid and must be credentialed by and contracted with a CHC-MCO to receive reimbursement for a CHC participant.
- All subcontracted providers providing home delivered meals, community transition, non-medical transportation, home adaptations, personal emergency response systems, vehicle modifications, and/or assistive technology must be enrolled directly as MA providers with OLTL.
- Subcontracted providers should enroll as an MA provider before January 1, 2018 to be eligible to contract with CHC-MCOs in the SW zone.

# MANAGED CARE ORGANIZATIONS

- The selected offerors were announced on August 30, 2016.



CHCProviders@amerihealthcaritas.com



information@pahealthwellness.com

UPMC Community HealthChoices

CHCProviders@UPMC.edu

# HOW THE PROVIDER RELATIONSHIP WITH DHS WILL CHANGE UNDER CHC

## WHAT DO PROVIDERS DO IF THEY DISAGREE WITH A CHC-MCO DECISION?

- The CHC-MCO must develop, implement, and maintain a Provider Dispute Resolution Process, which provides for informal resolution of provider disputes at the lowest level and a formal process for Provider Appeals.
- Each CHC-MCO must establish a Provider Appeal Committee, which providers can use to appeal the decision of a provider dispute. At least 25% of the membership of the Committee must be composed of providers/peers.
- The CHC-MCO and the provider must handle the resolution of all issues regarding the interpretation of provider agreements. This process does not involve DHS and provider appeals are not within the jurisdiction of the Department's Bureau of Hearings and Appeals.

# HOW THE PROVIDER RELATIONSHIP WITH DHS WILL CHANGE UNDER CHC

## WHAT ROLE DOES DHS PLAY IF PROVIDERS DISAGREE WITH A CHC-MCO DECISION?

- DHS must review and approve the CHC-MCOs policies and procedures for resolution of provider disputes and provider appeals.
- DHS will review reports from the CHC-MCOs on provider appeal decisions.
- The CHC-MCO and the provider must handle the resolution of all issues regarding the interpretation of provider agreements. This process does not involve DHS, and provider appeals are not within the jurisdiction of the Department's Bureau of Hearings and Appeals.

# ELIGIBILITY VERIFICATION SYSTEM

## HOW CAN A PROVIDER IDENTIFY A PARTICIPANT'S CHC PLAN?

- The current Eligibility Verification System or EVS will identify CHC participants and their CHC-MCO.
- The EVS methods, inquiry and response formats will not change with CHC implementation.
- EVS will display the CHC-MCO plan code information, along with the consumer's PCP if available.
- All other existing waiver benefit packages and HealthChoices managed care responses remain unchanged.
- Please reference Provider Quick Tip #11 for more information related to EVS.  
<http://www.dhs.pa.gov/publications/forproviders/QuickTips/>

# THIRD PARTY LIABILITY

## HOW IS THIRD PARTY LIABILITY HANDLED WITH CHC?

- Providers are required to check the Eligibility Verification System (EVS) to ensure a participant is eligible for services prior to rendering services.
- EVS will include information of the participant's CHC-MCO along with any Third Party Liability (TPL) information.
- When the financial responsibility for all or part of a participant's health care expense rests with an individual entity or program other than the CHC-MCO, such as Medicare or commercial insurance, providers must bill the other insurer first for payment of eligible services.
- Providers should obtain an Explanation of Benefits (EOB) from the primary insurer. Once the TPL has paid or denied the claim, CHC-MCOs (Medicaid) should be billed by the provider for the remainder of the claim.



# THIRD PARTY LIABILITY

## HOW IS THIRD PARTY LIABILITY HANDLED WITH CHC?

- When a recipient is eligible for both Medicare and Medicaid benefits, the Medicare program must be billed first if the service is covered by Medicare.
  - Some Medicare Advantage plans and Special Needs Plans may cover personal assistance services. The service coordinator and PAS agency are responsible for verifying coverage of services with other payors.
  - For more information, the PAS agency should check with the MCO to ensure that they are following the MCO's billing procedures correctly.

# CRITICAL INCIDENT REPORTING

## HOW IS CRITICAL INCIDENT REPORTING HANDLED?

- Providers must report in accordance with applicable requirements.
- CHC-MCOs and their network providers and subcontractors must report critical events or incidents via the Department's Enterprise Incident Management System.
- Using the Department's Enterprise Incident Management System, the CHC-MCOs must investigate critical events or incidents reported by network providers and subcontractors and report the outcomes of these investigations.



# CARE AND SERVICE COORDINATION IN CHC

## WHAT ARE THE OBJECTIVES OF SERVICE COORDINATION FOR CHC?

- Every participant receiving LTSS will choose a service coordinator.
- The service coordinator will coordinate Medicare, LTSS, physical health services, and behavioral health services.
- They will also assist in accessing, locating and coordinating needed covered services and non-covered services such as social, housing, educational and other services and supports.
- The service coordinator will also facilitate the person-centered planning team.
- Each participant will have a person-centered planning team that includes their doctors, service providers, and natural supports.



# CARE AND SERVICE COORDINATION IN CHC

## HOW DOES SERVICE COORDINATION CHANGE UNDER CHC?

- CHC-MCOs are responsible for service coordination under the CHC agreement and are given the flexibility to decide how to do it.
- The CHC-MCO will issue service authorizations to providers.
- Every participant receiving LTSS will choose a service coordinator.

# CARE AND SERVICE COORDINATION IN CHC

## WHAT IS THE IMPACT OF CONTINUITY OF CARE ON SERVICE COORDINATION?

- All existing service coordination entities or SCEs that are enrolled in Medicaid on the date of implementation for CHC each zone are covered by the continuity of care period.
- Participants who transition between CHC-MCOs after the implementation date will have a continuity of care period for their SCE for remainder of the 180 day continuity of care period.
- After the continuity of care period, the CHC-MCO can decide to continue contracting with SCEs, conduct service coordination themselves, or do a mixture of contracting and direct service coordination.
  - If a CHC-MCO chooses to end contracting with a SCE at the end of the continuity of care period, the CHC-MCO must comply with the provider termination requirements in Exhibit V, which includes notifying DHS and the participants and providing the DHS with a termination work plan.
  - If a SCE chooses to end contracting with a CHC-MCO at the end of the continuity of care period, the CHC-MCO must also comply with the provider notification requirement in Exhibit V.

# CARE AND SERVICE COORDINATION IN CHC

## HOW WILL CHC-MCOs RECEIVE INFORMATION ON EXISTING SERVICE PLANS AT IMPLEMENTATION?

- DHS will provide electronic files of approved service plan data to the appropriate CHC-MCO for implementation.

## WILL SERVICE PLAN INFORMATION BE TRANSFERRED WHEN WHEN A CONSUMER SWITCHES MCOs?

- CHC-MCOs must provide an electronic or hard paper copy of a participant's existing Comprehensive Medical and Service Record, including PCSPs, to the CHC-MCO to which a participant transfers. This should not exceed 5 business days after notification of the transfer.

# CARE AND SERVICE COORDINATION IN CHC

## HOW IS THE SERVICE PLAN IMPACTED BY CONTINUITY OF CARE?

- The CHC-MCO must continue services provided under all existing HCBS waiver service plans through all existing service providers, including service coordination entities, for one hundred eighty (180) days or until a comprehensive needs assessment has been completed and a PCSP has been developed and implemented, whichever date is later.

# SPECIFIC CHC SERVICES

## HOW WILL CHC-MCOS HANDLE PERSONAL EMERGENCY RESPONSE SYSTEMS?

- The CHC-MCOs are required to cover personal emergency response systems.
- Personal Emergency Response Systems (PERS) are subject to continuity of care provision.
- After continuity of care time period, CHC-MCOs can determine their provider network.
- Providers must agree to contractual terms and meet CHC-MCO participation requirements.
- PERS providers who are currently enrolled as a subcontractor to a service coordination entity must enroll as a Medicaid provider with OLTL and contract with CHC-MCOs to provide services to CHC participants.

# SPECIFIC CHC SERVICES

## HOW WILL CHC-MCOS HANDLE HOME MODIFICATIONS?

- The CHC-MCOs are required to cover home modifications.
- Home modification services is subject to continuity of care provision.
- After continuity of care time period, CHC-MCOs can determine their provider network.
- Providers must agree to contractual terms and meet CHC-MCO participation requirements.
- Home modification providers who are currently enrolled as a subcontractor to a service coordination entity must enroll as a Medicaid provider with OLTL and contract with CHC-MCOs to provide services to CHC participants.

# SPECIFIC CHC SERVICES

## HOW WILL PERSONAL ASSISTANCE SERVICE AGENCIES COORDINATE WITH MEDICARE-CERTIFIED HOME HEALTH AGENCIES?

- This will not be any different than under a current HCBS waiver. The service coordinator will work with the PAS agencies, home health agencies, and other providers to coordinate providing services for the participant.



# SPECIFIC CHC SERVICES

## WHAT IS THE IMPACT OF CHC ON PARTICIPANT-DIRECTED SERVICES ?

- Participant directed services, including Services My Way, will continue, and CHC-MCOs will offer the option to all participants.
- Just like today, the CHC-MCO's SCs will work with the participant to create an individualized service plan regarding type, scope, amount, duration and frequency of services needed. The SC will monitor the provision and utilization of services to ensure the participant's health and welfare.
- The CHC-MCOs are required to comply with state and federal regulations including the Department of Labor Fair Labor Standards Act regulations at 29 CFR Part 552 requirements related to minimum wage, overtime pay, and travel time.
  - Just like today, the SC will work with the individual if overtime pay requires a modification to the individual's budget.

# SPECIFIC CHC SERVICES

## HOW WILL PARTICIPANT-DIRECTED SERVICES BE PAID?

- The Fiscal Management System will continue.
  - The vendor may be different, depending on the outcome of an RFP in process.
- The CHC-MCOs are required to establish agreements and cooperate with the Commonwealth-procured FMS entity in order that necessary FMS services are provided to participants.
- The FMS will continue the same functions as today:
  - Prepare and distribute payroll and address federal, state, and local employment tax, labor, and workers compensation insurance rules and other requirements that apply when the participant functions as the employer of his or her workers;
  - Make financial transactions on behalf of the participant; and
  - Generate reports for participants, CHC-MCOs and OLTL.

# SPECIFIC CHC SERVICES

## HOW WILL CHC-MCOs HANDLE NURSING HOME TRANSITIONS?

- CHC-MCOs must provide nursing home transition or NHT activities to participants residing in nursing facilities who express a desire to move back to their homes or other community-based settings.
- The CHC-MCO can decide to continue contracting with current NHT providers, conduct NHT themselves, or do a mixture of contracting and direct NHT.
- Continuity of care includes NHT. Any nursing facility resident working with a NHT coordination agency at the time of CHC transition in their regional zone may continue working with that entity for at least 180 days following CHC transition.

# SPECIFIC CHC SERVICES

## HOW WILL ELECTRONIC VISIT VERIFICATION BE HANDLED?

- The 21st Century Cures Act requires Electronic Visit Verification (EVV) for Medicaid covered personal care services by January 1, 2019 and home health care services by January 1, 2023 (Sec. 207).
- CHC MCOs are required to have EVV systems that comply with this requirement.
- The EVV system must verify and record electronically (for example, through a telephone or computer-based system): the type of service performed; the individual receiving the service; the date of the service; the location of the service; and the time the service begins and ends.
- DHS is currently working on a Department wide approach to comply with the federal requirement.

# SPECIFIC CHC SERVICES

## HOW IS THE DEPARTMENT DEVELOPING THE EVV APPROACH?

- The Department is soliciting input from beneficiaries, family caregivers, provider agencies, and individuals who furnish personal care services or home health care services, managed care organizations, and other stakeholders on the current use of EVV in the commonwealth and the impact of EVV implementation.
- The Department would like feedback on existing best practices; EVV systems currently in use in Pennsylvania; and preference for a state, state-contracted or provider agency-operated EVV system.
- The Department intends to implement the EVV requirements so that the system is minimally burdensome and will take into account the input from stakeholders. Input received within 30 days will be reviewed and considered as the Department works to comply with the EVV requirements. Input should be submitted to [RA-PWEVVNotice@pa.gov](mailto:RA-PWEVVNotice@pa.gov).

# INFORMATION TECHNOLOGY RELATED IMPACTS

## WHAT SYSTEMS WILL BE USED FOR SERVICE COORDINATION?

- The CHC-MCOs will have an integrated technology system that supports service coordination and other operational aspects of CHC such as claims processing, participant information, and provider enrollment data.
- The CHC-MCOs will provide training to providers on the systems.

# CHC AND LIFE

## HOW DOES CHC IMPACT THE LIFE PROGRAM?

- The Living Independence for the Elderly (LIFE) program will be a choice for individuals residing in an area that offers the LIFE program.
- Individuals who already participate the LIFE program can remain in their LIFE program and will not be moved into CHC unless they specifically ask to change.
- CHC participants who would prefer to participate in a LIFE program and qualify to participate in LIFE will be free to do so.

# CHC AND ACT 150

## HOW DOES CHC IMPACT INDIVIDUALS IN ACT 150?

- The Act 150 program will continue as it does today.
- Individuals who are enrolled in Act 150 and are enrolled in both Medicaid and Medicare will be enrolled in CHC for physical health coverage. In addition to receiving services through CHC, these individuals will continue to be eligible to receive services through Act 150.
- CHC-MCO must coordinate with the Act 150 program.
- The Quality Management Efficiency Teams (QMETs) will continue to monitor Act 150 providers.



# QUALITY

## WHAT MEASURES WILL BE USED TO MEASURE QUALITY?

- Comprehensive list of *proposed* measures

### National

- Healthcare Effectiveness Data & Information Set (HEDIS)(Adults)
- CMS Adult Core
- CMS Nursing Facility
- Consumer Assessment of Healthcare Providers & Systems (CAHPS)
- CMS Medicare measures for Dual Eligible Special Needs Plans

### State

- LTSS Community Based Services
- Service Coordination and Care Coordination
- Grievances, Appeals & Critical Incidents
- Rebalancing
- CHC HCBS Waiver Assurances

### Launch Indicators

- Key data points provided frequently during launch
- Focus on:
  - Continuity of Services
  - LTSS Provider Participation

# Statewide Quality Strategy Plan

## Themes:

- Ensure that **participants AND providers** have mechanics in place to include:
  - An independent system (Beneficiary Support System, as defined under the managed care final rule).
  - Participant and provider hotline numbers continue at the state level.
  - Continuous communication
- Continue to **promote stakeholder engagement** among:
  - DHS
  - MCO
  - Providers
  - Participants
  - Advocates
- Continue to have **program transparency**:
  - Report on performance measures and outcomes to stakeholders:
  - Consumer and provider satisfaction surveys
  - Critical incidents / reports of abuse
  - Incorporate pay for performance initiatives
  - Monitoring of program
- Ensure **participant choice**
  - Community living
  - Nursing home
  - Service providers
- **Diversity inclusion**
  - Ethnicity
  - LGBT population
  - Various translations available



# PARTICIPANTS

# PARTICIPANTS

## WILL PARTICIPANTS BE ABLE TO USE THE OLTL HOTLINE? ?

- Participants should work with their CHC-MCO to address concerns.
- The CHC-MCOs will have complaint and grievance process and will support the Medicaid Fair Hearing process.
- The participant hotline will still be available for unresolved issues with MCOs.

# ASSISTING PARTICIPANTS

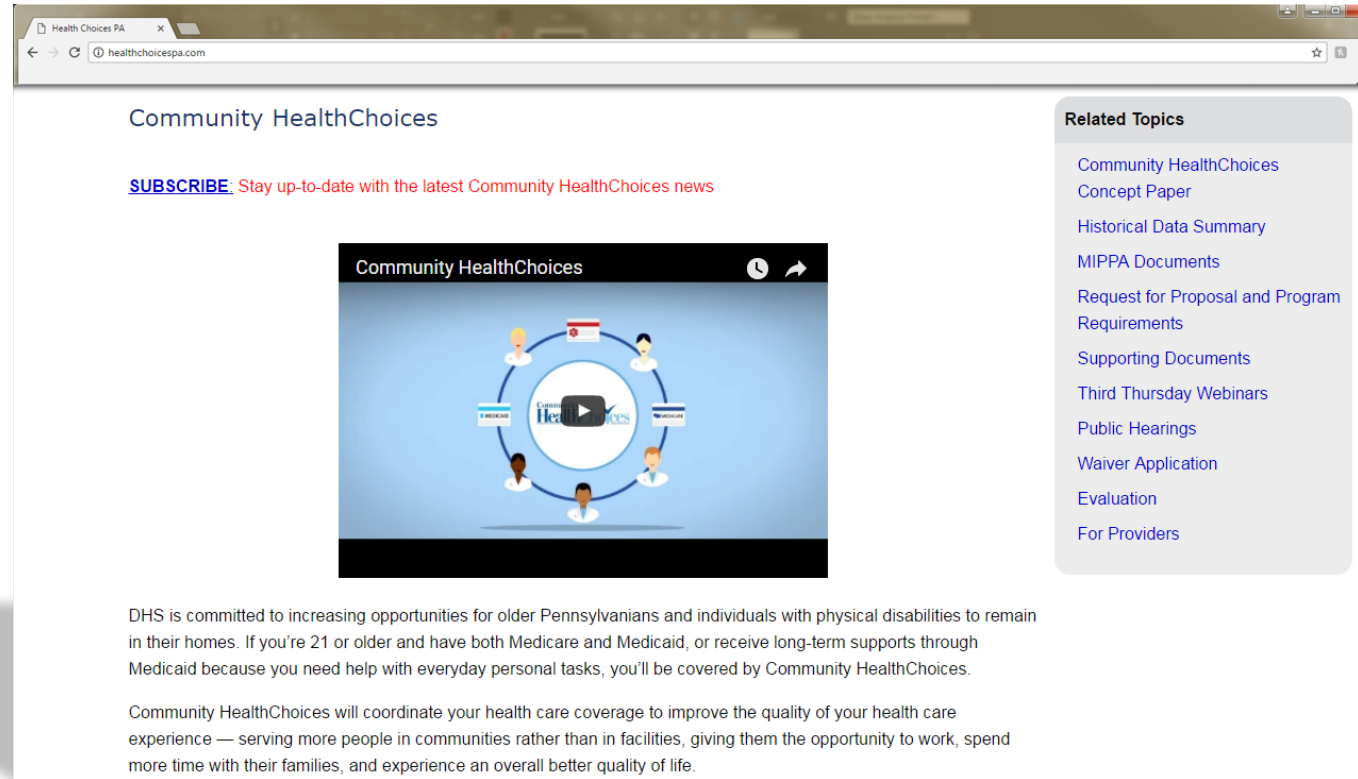
## WHAT CAN PROVIDERS DO TO ASSIST THEIR PARTICIPANTS?

- Encourage them to participate in Community HealthChoices Third Thursday webinars to learn more about CHC.
- Encourage them to participate in stakeholder engagements.
- Advise them to watch for information about CHC in the mail.
- Ask them to read any CHC-related information by the Department.
- Encourage them to participate in upcoming educational sessions hosted by the Department.
- Encourage them to select a CHC-MCO by the date identified by the Department.
- Encourage them to subscribe to the CHC listserv.



# COMMUNICATIONS

# CHC WEBSITE



[www.HealthChoicesPa.com](http://www.HealthChoicesPa.com)

# PARTICIPANTS

## AWARENESS FLYER

- Mailed six months prior to implementation.

## AGING WELL EVENTS

- Participants will receive invitations for events in their area.

## SERVICE COORDINATORS

- Will reach out to their participants to inform them about CHC.

## NURSING FACILITIES

- Discussions about CHC will occur with their residents.

## PRE-TRANSITION NOTICES AND ENROLLMENT PACKET

- Mailed four months prior to implementation.



# PROVIDERS

- Bi-weekly email blasts on specific topics
  - ✓ Examples: Billing, Service Coordination, Medicare, HealthChoices vs. CHC, Continuity of Care
- Established provider webpage
- Provider events in local areas to meet with MCOs and gain information about CHC



# RESOURCE INFORMATION

## COMMUNITY HEALTHCHOICES WEBSITE

[www.healthchoicespa.com](http://www.healthchoicespa.com)

## MLTSS SUBMAAC WEBSITE

[www.dhs.pa.gov/communitypartners/informationforadvocatesandstakeholders/mltss/](http://www.dhs.pa.gov/communitypartners/informationforadvocatesandstakeholders/mltss/)

## CHC LISTSERV // STAY INFORMED

<http://listserv.dpw.state.pa.us/Scripts/wa.exe?SUBED1=oltl-communityhealthchoices&A=1>

EMAIL COMMENTS TO: [RA-MLTSS@pa.gov](mailto:RA-MLTSS@pa.gov)

PROVIDER LINE: 1-800-932-0939

PARTICIPANT LINE: 1-800-757-5042



# QUESTIONS