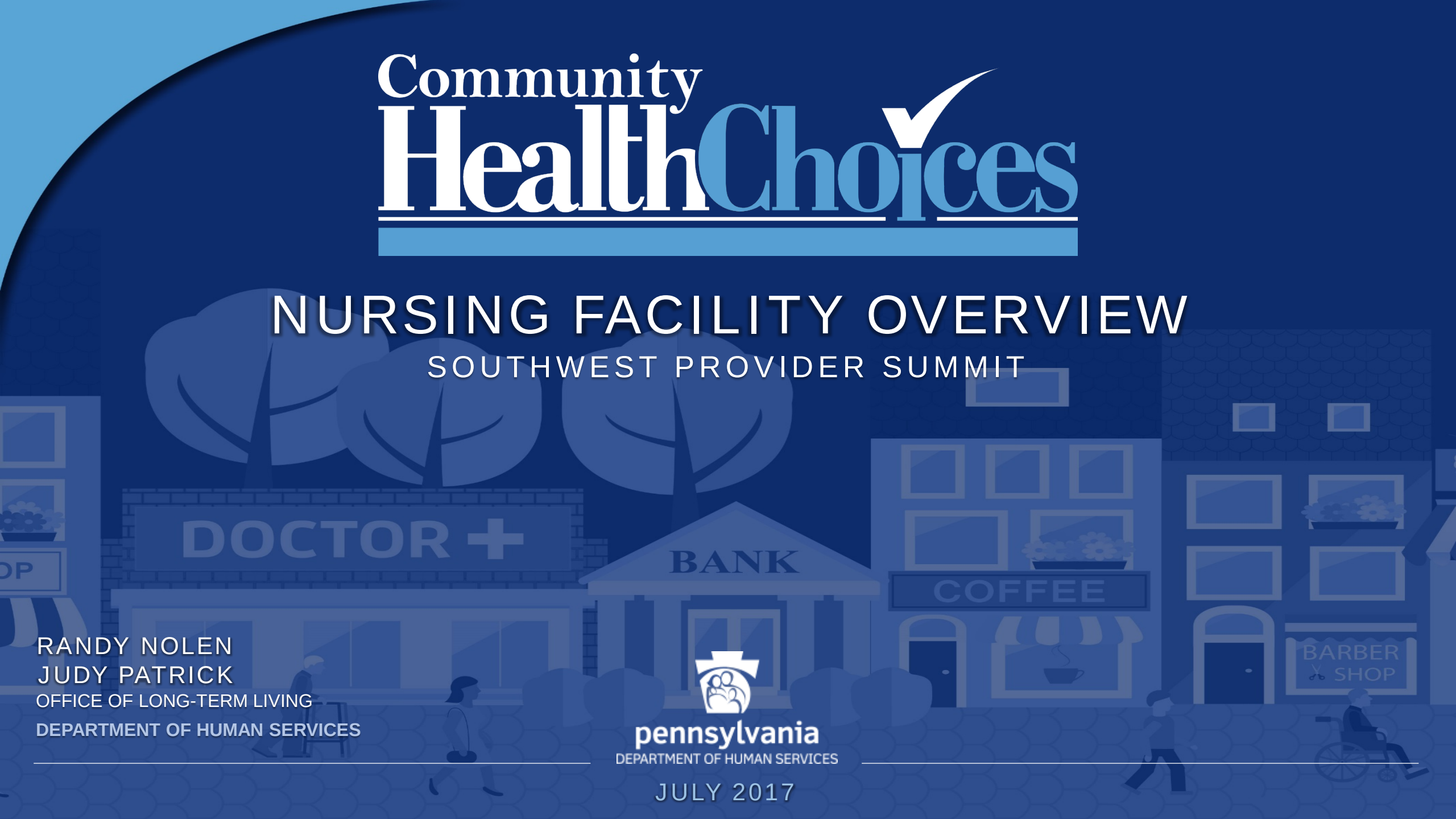
Community HealthChoices

NURSING FACILITY OVERVIEW

SOUTHWEST PROVIDER SUMMIT



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FEE-FOR-SERVICE

- The fee-for-service (FFS) payment system for nursing facility (NF) services will remain in effect during and after implementation of Community HealthChoices (CHC).
- The Department of Human Services (Department) will continue to set quarterly per diem rates for each nonpublic NF and annual per diem rates for each county NF provider.
- NFs shall continue to submit cost reports and case-mix index (CMI) reports.
- Field Operations will continue to monitor:
  - ✓ Minimum data set
  - ✓ Pre-admission screening and resident review
  - ✓ Medical Assistance (MA) billing until CHC start date

ANY WILLING PROVIDER

Each CHC managed care organization (CHC-MCO) must contract for at least 18 months with any Medicaid NF that:

- Accepts CHC-MCO's payment rates; and
- Complies with quality and other standards and terms established by the Department and the CHC-MCO
- For Phase I (Southwest zone): January 1, 2018 – June 30, 2019

CONTINUITY OF CARE

FOR NURSING FACILITIES

A participant who resides in a NF located in the CHC zone on the implementation date must be allowed to receive NF services from the same NF until the earliest date any of the following occur:

- The participant's stay in the NF ends.
- The participant is disenrolled from CHC
- The NF is no longer enrolled in the MA program

A change in CHC-MCO, temporary hospitalization, or therapeutic leave does not interfere with or terminate this continuity-of-care period as long as the participant remains a resident of the NF.

CONTINUITY OF CARE

FOR NURSING FACILITIES

- Participants who are admitted to a NF after the start date for the CHC-MCO, or who do not qualify for the extended continuity of care period, will receive the standard continuity of care available for all Medicaid participants.

- For all participants, the CHC-MCO must comply with continuity of care requirements for continuation of providers, services, and any ongoing course of treatment outlined in MA Bulletin 99-03-13, Continuity of Care for Recipients Transferring Between and Among Fee-for-Service and Managed Care Organizations.

CONTINUITY OF CARE

FOR NURSING FACILITIES

- If the NF leaves the network and a participant is ineligible to receive an extended continuity-of-care period, the participant may continue to receive NF services, if eligible, from the NF for up to 60 days from whichever is greater:
  - ✓ The date the participant is notified by the CHC-MCO of the termination or pending termination of the provider; or
  - ✓ The date of the provider termination
- **Exception:** The provider is being terminated for cause as described in 40 P.S. § 991.2117(b).

PAYMENT FOR NF SERVICES

NF RESIDENT MOVES FROM HEALTHCHOICES (HC) TO CHC

- The HC-MCO will pay for up to 30 days.
- The HC-MCO will pay for Day 31 through the date the eligibility determination is made if resident is found eligible to receive NF services
- The CHC-MCO will pay beginning the day after the resident is found eligible to receive NF services

NF RESIDENT MOVES FROM FFS TO CHC

If the resident is determined eligible to receive NF services:

- FFS will pay for the retroactive period
- FFS will pay from date of application to the date eligibility is determined
- The CHC-MCO will pay beginning the day after eligibility is determined

PAYMENT FOR NF SERVICES

CHC NURSING FACILITY INELIGIBLE (NFI) DUAL

- The CHC-MCO will pay for up to 30 days (including hospital reserve bed days and therapeutic leave days)
- Once the NFI participant is found eligible for long-term care services (LTSS), the NF can bill the CHC-MCO for providing services beyond 30 days.
- The CHC-MCO shall not pay for services that a participant is not eligible to receive.

PAYMENT FOR NF SERVICES

NF RATES FOR THE FIRST 36 MONTHS PER ZONE

- Average of each NF's FFS rates in effect for the four quarters prior to implementation
- Southwest – Calendar Year 2017 quarters
- These rates will not be adjusted over the 36-month timeframe.
- The CHC-MCOs and NFs may agree to higher rates.
- The CHC-MCOs and NFs may agree to lower rates initially under an alternative payment methodology.
- The payments funded through Appendix 4 of the agreement between the Department and each CHC-MCO (relating to NF access to care payments) and exceptional durable medical equipment (DME) shall be in addition to a NF's rate.

PAYMENT FOR NF SERVICES

SUPPLEMENTAL PAYMENTS REMAINING IN FFS

- Health Care-associated Infection (HAI)
- Legislative adds, such as nonpublic Medical Assistance Day One Incentive (MDOI).

PAYMENT FOR NF SERVICES

SUPPLEMENTAL PAYMENTS IN THE CAPITATION RATE

- Exceptional DME
- Assessment-related allowable cost for nonpublic NFs (Appendix 4)
- Quarterly supplemental payments for nonpublic NFs (Appendix 4)
- County MDOI (Appendix 4)
- County Quality and Access to Care Payments (Appendix 4)
- Disproportionate Share Incentive*
- Supplemental Ventilator Care and Tracheostomy Care*

** Payment history related to these payments was used in the development of the CHC capitated rates, but there is no requirement for a separate payment in addition to the per diem.*

PAYMENT FOR NF SERVICES

EXCEPTIONAL DME

- The CHC-MCOs must provide a separate payment for exceptional DME in addition to the per diem rate.
- The amount of the additional payment authorized is based upon the necessary, reasonable, and prudent cost of the exceptional DME.
- The Department will continue to publish an annual list of exceptional DME by notice in the Pennsylvania Bulletin in July.
- Purchased equipment will belong to the participant.

PAYMENT FOR NF SERVICES

TRANSPORTATION FOR NF RESIDENTS

- Emergency medical, nonemergency medical, and nonmedical transportation
  - ✓ Payment – MCO
  - ✓ Coordination – NF

CLAIMS

- CHC-MCOs must have a provider claims educator on staff tasked with facilitating between grievances, claims processing, and provider relations systems and will:
  - ✓ Educate contracted and non-contracted providers regarding appropriate claims submission guidelines
  - ✓ Communicate frequently with providers to provide effective exchange of information and to obtain feedback regarding appropriate claims-submission practices
- CHC-MCOs must operate provider services functions during regular business hours, including assisting providers with claims payment issues.

CLAIMS

CLAIMS RECEIVED FROM ANY PROVIDER

- 90.0% of clean claims must be adjudicated within 30 days of receipt.
- 100.0% of clean claims must be adjudicated within 45 days of receipt.
- 100.0% of all claims must be adjudicated within 90 days of receipt.

CLAIMS

PATIENT PAY

- NFs shall continue to collect patient pay.
- NFs shall continue to deduct costs for medical services from the resident's payment toward the cost of NF services.

CLAIMS

PROVIDER PREVENTABLE CONDITIONS (PPC)/ PREVENTABLE SERIOUS ADVERSE EVENTS (PSAE)

- NFs shall report PPCs/PSAEs related to CHC-MCO participants to the applicable CHC-MCO.
- The CHC-MCO may not pay for services related to PPCs unless the condition existed prior to the initiation of treatment for the patient.
- NFs shall continue to report FFS related PPCs/PSAEs to the Department.

CLAIMS

DISPUTE RESOLUTION

- CHC-MCOs will handle disputes regarding claims submission and payment reconciliation.
- Information on how to begin the appeals process and details on what the process will entail will be included in the CHC-MCOs provider manuals.
- CHC-MCOs are required to complete provider manuals and submit them to the Department's Office of Long-Term Living (OLTL) for review.

SERVICE COORDINATION

- The CHC-MCO's person-centered planning team is required to develop and implement a person-centered service plan (PCSP) for all nursing facility clinically eligible participants and others who request or require service coordination.

- PCSP — A written description of participant-specific health care, LTSS and wellness goals to be achieved, and the amount, duration, frequency and scope of the covered services to be provided to a participant in order to achieve such goals, which is based on the comprehensive assessment of the participant's health care, LTSS, and wellness needs and preferences.

SERVICE COORDINATION

- The CHC-MCO must conduct needs assessments according to the agreement with the Department; they will use the InterRAI Home Care assessment. The CHC-MCO will use this information to develop a participant's PCSP.
- NFs will continue to conduct assessments of a resident's needs, strengths, goals, life history and preferences using the Centers for Medicare & Medicaid Services' (CMS) Minimum Data Set (see 42 CFR 483.20; relating to resident assessment). The NF uses this information to develop a resident's comprehensive person-centered care plan.
- The CHC-MCO and the NF need to coordinate a participant's PCSP and comprehensive person-centered care plan.

SERVICE COORDINATION

NURSING HOME TRANSITION

- CHC-MCOs must provide NHT activities to participants residing in NFs who express a desire to move back to their homes or other community-based settings.
- NF requirements under 42 CFR 483.15(c)(7) state that a facility must provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. This orientation must be provided in a form and manner that the resident can understand.

SERVICE COORDINATION

BEHAVIORAL HEALTH

- Behavioral health is a component of the PCSP.
- Service coordinators are required to actively coordinate with individuals and entities for behavioral care delivery.
- CHC-MCOs will have a behavioral health coordinator to monitor for compliance with the agreement and coordinate participant care needs with BH-MCOs.

COMMUNICATIONS

FOR PARTICIPANTS

- September 2017
  - ✓ Pre-transition notices and CHC enrollment information sent to Phase I participants
  - ✓ Letter instructs participants that the Independent Enrollment Broker will send them information about selecting a CHC-MCO.
- September – November 2017
  - ✓ Phase I participants will select their plan

Note: Aging Well will conduct training for NFs in August.

INDEPENDENT ENROLLMENT BROKER (IEB)

THE IEB IS RESPONSIBLE FOR THE FOLLOWING ACTIVITIES:

- Educate individuals on their rights and responsibilities in LTSS, opportunities for self-direction, appeal rights, and provider choices within the CHC-MCO network
- Provide applicants with choice of receiving NF institutional services; home- and community-based waiver services; services through the Living Independence for the Elderly (LIFE) program for individuals aged 55 and over; or no services, and electronically document the applicant's choice
- Respond to questions about CHC announcement and plan assignment/selection letters
- Respond to questions about how CHC enrollment and benefits interrelate with Medicare coverage, and refer applicants to the State Health Insurance Assistance Program (APPRISE), as necessary

INDEPENDENT ENROLLMENT BROKER (IEB)

THE IEB IS RESPONSIBLE FOR THE FOLLOWING ACTIVITIES:

- If they select CHC, provide applicants with a choice of MCOs
- Assist the applicant to obtain a completed physician certification form (MA-51) from the individual's physician
- Refer the applicant to the independent assessment entity for the Functional Eligibility Determination
- Assist the participant to complete the financial eligibility determination paperwork
- Facilitate the transfer of the new enrollee to their selected MCO, including sending copies of all completed assessments and forms

TRANSITIONS

TRANSITIONING BETWEEN CHC-MCOs

- Transition between CHC-MCOs is facilitated by participant's service coordinator
- CHC-MCOs must provide MA services to participants in accordance with the eligibility information included on the Monthly Participant File and/or Daily Participant File provided by DHS to each MCO
- NFs should check the Eligibility Verification System to determine a resident's MCO

TRANSITIONS

TERMINATION OF NETWORK PROVIDER

When a CHC-MCO terminates a network provider, the CHC-MCO must:

- Notify the Department in writing 90 days in advance
- Submit to the Department a provider termination work plan within 10 days of the notice to the Department
- Notify the resident 45 days prior to the effective date of the provider's termination
- Pay provider for up to 60 days or until alternative network provider begins to deliver same services

TRANSITIONS

TERMINATION OF NETWORK PROVIDER

When a network provider informs the CHC-MCO that it no longer intends to participate in the CHC-MCO's network, the CHC-MCO must:

- Notify the Department in writing 90 days in advance
- Submit to the Department a provider termination work plan within 10 days of the notice
- Notify the resident 45 days prior to the effective date of the provider's termination
- Pay provider for up to 60 days or until alternative network provider begins to deliver same services

SETTING RULE FOR LTSS

- 79 FR 2948-3039, codified at 42 CFR 441.301(c)(4)-(c)(6)
- CHC-MCOs must provide services in the least restrictive, most integrated setting
- Setting must be integrated in the community; be participant selected; ensure privacy, dignity and respect; optimize autonomy and independence; and facilitate choice regarding services and providers
- Final rule specifically excludes NFs
- OLTL issued bulletin 59-16-14 to provide guidance to home and community-based services providers

QUESTIONS