Community HealthChoices

OLTL Updates and Service Coordination Discussion

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CHC UPDATE

SOUTHWEST DENIAL NOTICE PROCESS TRAINING

- Conducted on July 19th by the Department of Human Services, Office of Legal Counsel.
- Mandatory training for MCO staff directly involved in writing participant denial notices.
- Reviewed examples of denial notices containing insufficient language and offered suggestions to the MCOs.
- OLTL is requiring the CHC-MCO to submit all denial notices to OLTL for review. OLTL will be reviewing the notices to ensure the language in the denial notice contains a sufficient amount of information for the participant to fully understand why a specific service is being denied or reduced.

SOUTHWEST PERSON-CENTERED SERVICE PLAN TRAINING STATUS

- Focus:
  - Training for service coordinators and employees on person-centered service planning:
    - Comparative analysis of service plans
    - Fundamentals in person-centered service planning
    - InterRAI-HC and other tools
  - Validation of training by DHS

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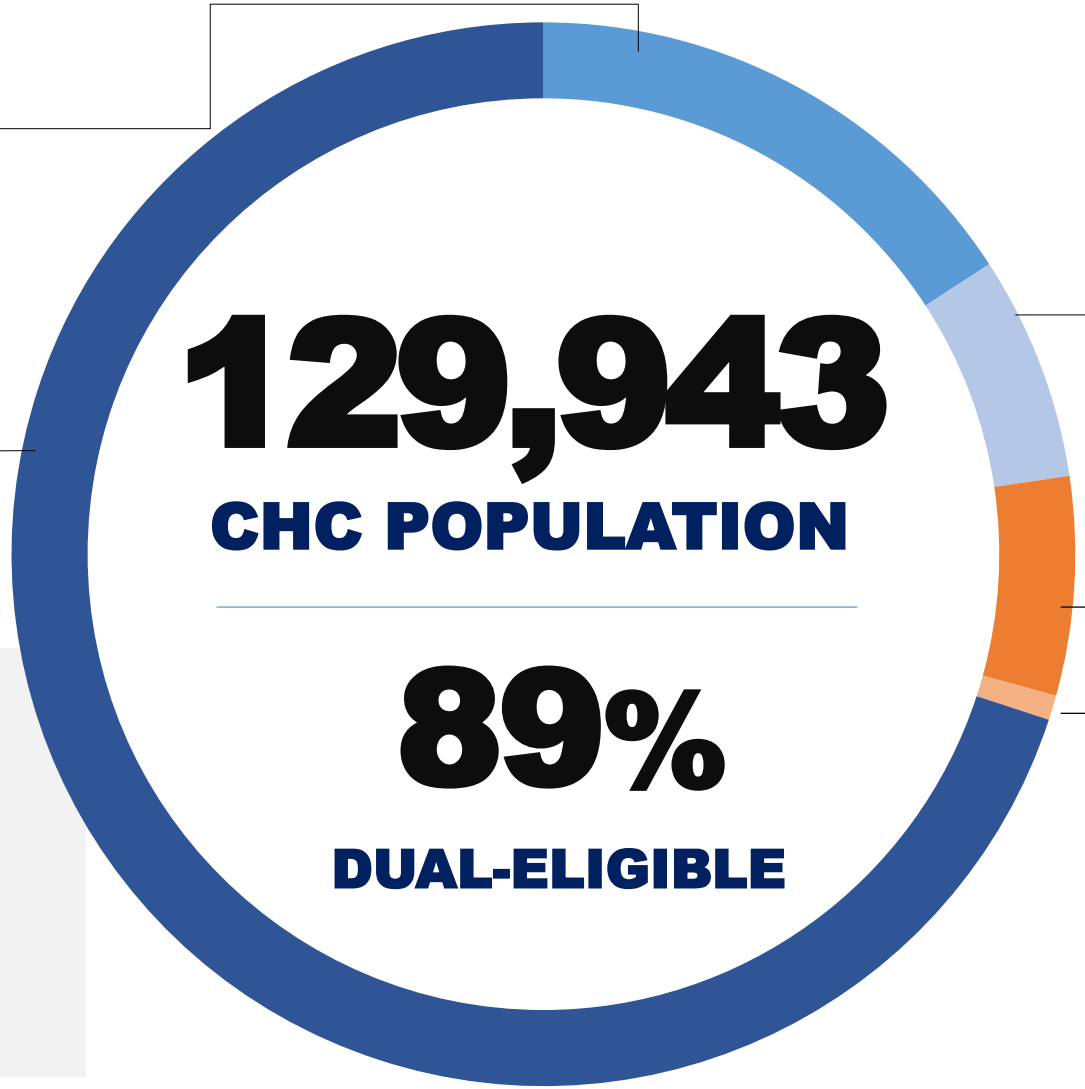
SOUTHEAST IMPLEMENTATION

CHC SOUTHEAST POPULATION



25%
31,845
Duals in Waivers

54%
70,718
Healthy Duals

9%
12,116
Duals in Nursing Facilities

11%
13,914
Non-duals in Waivers

1%
1,350
Non-duals in Nursing Facilities

129,943
CHC POPULATION

89%
DUAL-ELIGIBLE

36%
IN WAIVERS

10%
IN NURSING FACILITIES

Data as of August 6, 2018.

SOUTHEAST IMPLEMENTATION FOCUS

- OBRA Assessments
  - Assessments are 99% completed
- Provider Outreach and Education
- Population Identification
- Readiness Review
- Participant Communication

PARTICIPANT COMMUNICATIONS

AWARENESS FLYER

- Mailed five months prior to implementation. Southeast: July 23, 2018

AGING WELL EVENTS

- Participants will receive invitations for events in their area. Southeast: August 8, 2018

PRE-TRANSITION NOTICES AND ENROLLMENT PACKET

- Mailed four months prior to implementation. Southeast: August 20, 2018

SERVICE COORDINATORS

- Will reach out to their participants to inform them about CHC. Southeast: September 2018

NURSING FACILITIES

- Discussions about CHC will occur with their residents. Southeast: September 2018

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SERVICE COORDINATOR ROLE IN CHC

OBJECTIVES OF SERVICE COORDINATION IN CHC

The primary objective of service coordination is to oversee the person-centered service planning process and to provide support for CHC program participants, specifically those individuals in need of long-term supports and services (LTSS) and those with unmet needs, in the following ways:

1. The identification of needed services through the Comprehensive Needs Assessment process.
2. The assurance of appropriate service delivery that supports both a participant's needs and their preferences through the management of the person-centered planning process and the development and implementation of the participant's person-centered service plan.
3. The coordination of the participant's long-term care services with all of their other services including those provided by Medicare, behavioral health, and Medicaid physical health.

SERVICE COORDINATION: FFS VS. MANAGED CARE

FEE-FOR-SERVICE

- Service coordination is a billable service under the HCBS waivers.
- Service coordination identifies, coordinates, and assists participants in gaining access to needed waiver services and State Plan services, as well as non-Medicaid funded medical, social, housing, educational and other services and supports.

CHC

- The CHC managed care organization (CHC-MCO) will provide service coordination as an administrative function of the CHC-MCO.
- Service coordinators lead the person-centered service planning process and oversee the implementation of person-centered service plans (PCSPs).
- The service coordination function must be provided by an appropriately qualified service coordinator employed by, or under contract with, the CHC-MCO.

HOW WILL SERVICE COORDINATION BE DIFFERENT IN CHC?

While the service coordination role is expanded in CHC, the fundamental requirements are the same as they were in the fee-for-service waivers.

FEE-FOR-SERVICE

- In the performance of providing information to participants, the service coordinator will:
  - Inform participants about: the waiver, required needs assessments, the participant-centered planning process, service alternatives, service delivery options (opportunities for participant-direction), roles, rights, risks and responsibilities.
  - Inform participants on fair hearing rights and assist with fair hearing requests when needed and upon request.

CHC

- Service coordinators are responsible to inform participants about: available LTSS, required needs assessments, the participant-centered service planning process, service alternatives, service delivery options (opportunities for participant-direction), roles, rights, risks and responsibilities, fair hearing rights and assist with fair hearing requests when needed and upon request.
- Service coordinators are also responsible for ensuring the health, welfare, and safety of the participant on on-going basis.

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HOW WILL SERVICE COORDINATION BE DIFFERENT IN CHC?

FACILITATING ACCESS TO NEEDED SERVICES AND SUPPORTS

FEE-FOR-SERVICE

- Collect additional necessary information, including -- at a minimum -- participant preferences, strengths and goals to inform the development of the PCSP
- Assist the participant and his/her service planning team in identifying and choosing willing and qualified providers
- Coordinate efforts and prompt the participant to ensure the completion of activities necessary to maintain waiver eligibility

CHC

- Collect information to inform the development of the PCSP, including -- at a minimum -- the participant's preferences, strengths and goals
- Collect required documentation for the re-evaluation of clinical eligibility, at least annually or more frequently as needed in accordance with department requirements
- Assist the participant and his/her person-centered planning team to identify and choose willing and qualified providers
- Coordinate efforts and prompt the participant to complete activities necessary to maintain waiver eligibility
- **Explore coverage of services to address participant-identified needs through other sources, including services provided under the State Plan, Medicare, and/or private insurance or other community resources**
- **Actively coordinate with other individuals and/or entities essential in the physical and/or behavioral care delivery for the participant, including other care coordinators, to ensure seamless coordination between physical, behavioral and support services.**

HOW WILL SERVICE COORDINATION BE DIFFERENT IN CHC?

CHC

- Service coordinators are also responsible for:
  - Overseeing pre-tenancy and transition services for housing, which prepare and support the participant's move to housing in an integrated setting.
    - These services include assistance to obtain and retain housing, activities to foster independence, and assistance in developing community resources to support successful tenancy and maintain residency in the community.
  - Supporting individuals in nursing facilities, as well as individuals receiving LTSS in the community.

CONTINUITY OF CARE

- MCOs are required to contract with all willing and qualified existing Medicaid providers, including service coordination agencies, for 180 days after CHC implementation.
- Participants may keep their existing providers for the 180-day continuity of care period after CHC implementation.
- Providers participating during the continuity of care period will have to develop a contractual relationship with the CHC-MCOs and bill the MCOs for their services.
- After the HCBS continuity of care period is over, service coordination will fully convert to an administrative function of the CHC-MCOs.

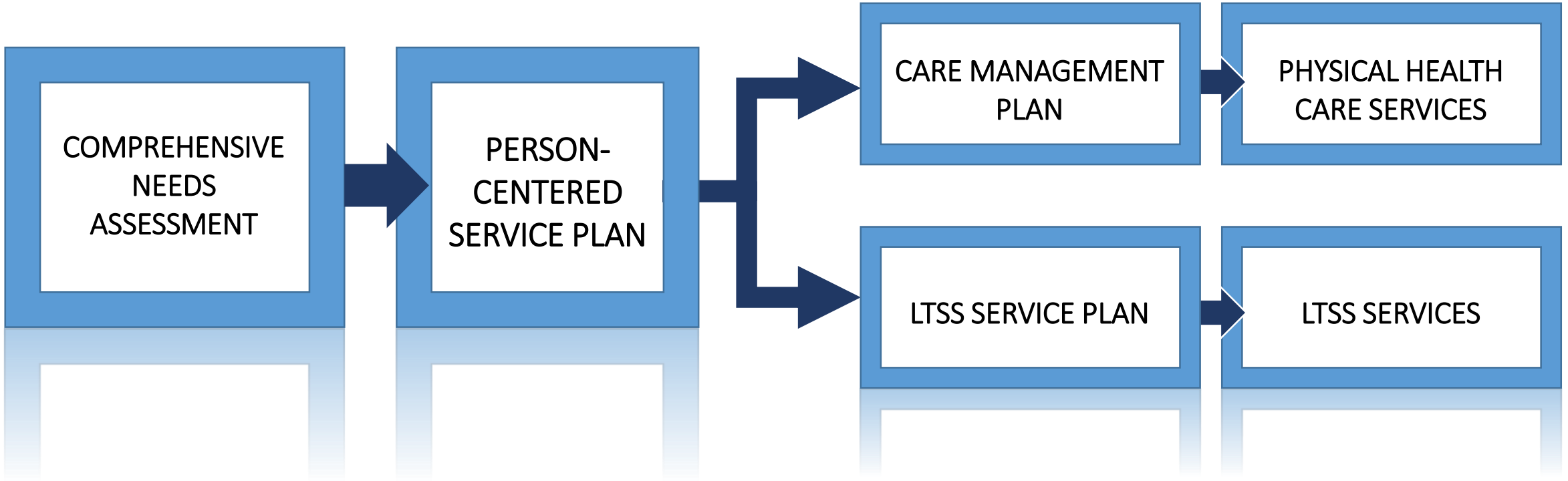
SERVICE COORDINATION AS AN ADMINISTRATIVE FUNCTION

- The CHC-MCO must provide service coordination as an administrative function through appropriately qualified staff or contracts with service coordination entities.
- Service coordinators will either be directly employed by the CHC-MCOs or will support this service through a subcontractor relationship after the continuity-of-care period expires.
- Currently, service coordinators serve as fee-for-service providers in the HCBS waivers.

SERVICE COORDINATOR STAFFING REQUIREMENTS

- **Service coordinators must be** a registered nurse or have a Bachelor's degree in social work, psychology, or other related fields with at least three (3) years of experience in a social service or healthcare related setting. Service coordinators hired prior to the CHC zone implementation date must have the qualifications and standards proposed by the CHC-MCOs and approved by the Department.
- **Service coordinator supervisors must be** an registered nurse or a Pennsylvania-licensed social worker or Pennsylvania-licensed mental health professional with at least 3 years of relevant experience. Service coordinator supervisors hired prior to the CHC zone implementation date (who do not have a license) must either: 1) obtain a license within the first year of the start of CHC; or 2) have the qualifications and standards proposed by the CHC-MCOs and approved by the department.

PERSON-CENTERED SERVICE PLANNING (PCSP)



NURSING HOME TRANSITION (NHT)

- NHT is an administrative role for the CHC-MCOs.
- CHC-MCOs must provide 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 must provide NHT activities using appropriately qualified staff, whether employed by or under contract with the CHC-MCO.
- Service coordinators will participate in these activities, although the CHC-MCOs may have dedicated staff focused on the responsibilities of this role.

COORDINATION WITH NON-MEDICAID SERVICES

- For a participant who is receiving home-and community-based services other than through a HCBS waiver on the participant's start date, the CHC-MCO service coordinators must coordinate the participant's transition into CHC with entities that are providing care or service coordination to the participant at the time of their CHC enrollment.
- The CHC-MCO service coordinators must coordinate with entities providing these services outside of CHC including, but are not limited to, the Act 150 program, the OPTIONS program or OMAP's Special Needs Unit.

MONITORING

MONITORING MISSED SERVICES AND PERSON-CENTERED SERVICE PLANS

- OLTL has developed report requirements to capture LTSS service plan changes, missed services, timeliness of service plan activities, service denial notices, and complaints and grievances through the continuity of care period and ongoing after the continuity of care period ends.
- These reports help OLTL to assure participants are receiving services and to help ensure participant health and safety.
- Service coordinators play a critical role in providing information or taking follow up steps to the CHC-MCOs to assist in monitoring efforts.
- OLTL staff monitors the reports and addresses concerns with the CHC-MCOs. The MCOs may request additional information from service coordinators to assist in responding to OLTL requests.

LESSONS LEARNED FROM THE SOUTHWEST IMPLEMENTATION

- Earlier training for external service coordinators both to support the continuity of care period and to clarify the role and function of the service coordinator in CHC
- Ongoing and improved communication with the CHC-MCOs and external service coordinators
- Data clean-up and standardization in the legacy case management systems (HCSIS/SAMS)
- Earlier user account set-up in the CHC-MCO systems
- Earlier and more rapid change of EIM user account information to reflect new relationship in CHC with the CHC-MCOs
- An evaluation and augmented training of both internal and external service coordinator understanding of the person-centered planning process
- Service coordinator participation in data clean-up efforts

QUESTIONS FOR SOUTHWEST SERVICE COORDINATORS

- How did you prepare yourself for the transition to CHC?
- How did you make contact with the CHC-MCOs during the Southwest implementation period?
- How did you approach service coordination training offered by the CHC-MCOs?
- How did you communicate to participants in your case load about CHC?
- What did you see as the most significant challenge with the CHC transition and how did you address it?
- What is the most important lesson learned for your agency?
- What would you consider to be most positive change with regard to CHC?

QUESTIONS