Community HealthChoices

CHC Overview

Third Thursday Webinar
June 21, 2018

Office of Long-Term Living
Department of Human Services

pennsylvania
DEPARTMENT OF HUMAN SERVICES

Community HealthChoices

CHC LAUNCH UPDATE

2018 FOCUS

CHC SOUTHWEST LAUNCH:

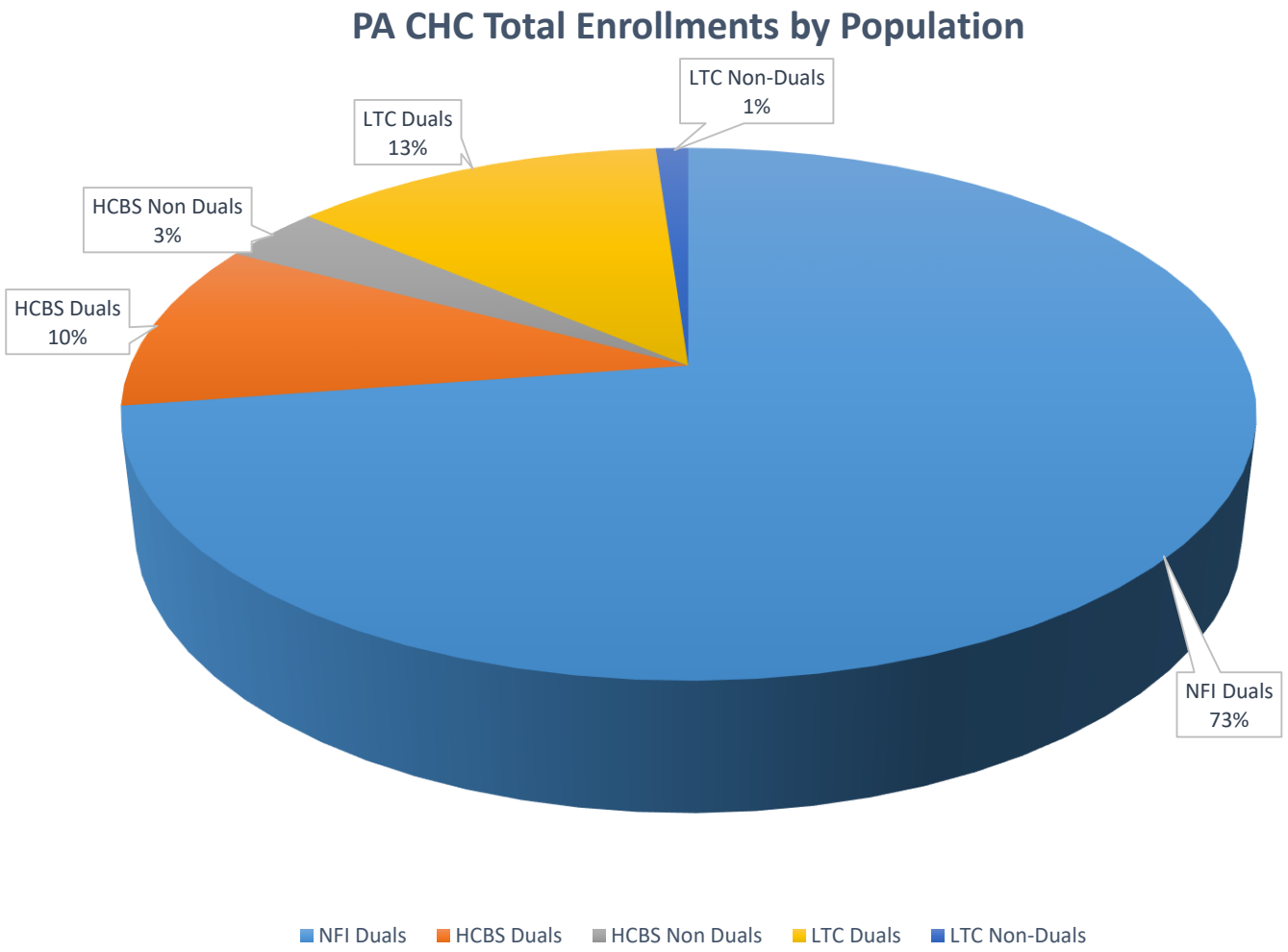
- Assuring no participant service interruptions
- Assuring no interruption in provider payment
- Successful launch first phase

CHC SOUTHEAST IMPLEMENTATION:

- Preparation for January 1, 2019 launch
- Comprehensive participant communication
- Robust readiness review
- Provider communication and training
- Pre-transition and plan selection for Southeast participants
- Incorporation of Southwest implementation and launch lessons learned

Community HealthChoices

CHC SOUTHWEST (Population Distribution)



CHC SOUTHWEST (Plan Distribution)

Distribution	AmeriHealth Caritas	Pennsylvania Health and Wellness	UPMC COMMUNITY HEALTHCHOICES
Percentage	19%	27%	54%

Community HealthChoices

IMPLEMENTATION FEEDBACK

PARTICIPANT FEEDBACK

Concerns about Continuity of Care Ending:

- Participants expressed concerns that the end of the continuity of care period, a six-month period designed to ease the transition from the prior fee-for-service program to managed care by continuing existing home and community-based services, would mean that prior services would be cut by the CHC managed care organizations.

PARTICIPANT FEEDBACK

A Lack of Training and Information by Service Coordinators on the Person-Centered Planning Process:

- CHC as a program, as did the previous fee-for-service program, required that all long-term care community based service plans be developed with the needs and preferences of participants as the basis for how service plans are designed.
- Participants stated that service coordinators were relying either too heavily or completely on the assessment tool to determine what services are needed for participants and did not consider the input from participants outside the responses to the questions in any meaningful way.

PARTICIPANT FEEDBACK

Challenges with Transportation:

- Participants stated that access to non-medical transportation and non-emergency medical transportation has been complicated by the implementation of CHC.
- Previously, they were able to work with service coordinators who were able to facilitate all of their transportation requirements in one place.
- CHC is now requiring participants to use a broker affiliated with the CHC-MCOs to coordinate non-medical transportation and coordinate non-emergency medical transportation through the Medical Assistance Transportation Program.

PROVIDER FEEDBACK

- **Problems Experienced:**
  - Communication challenges with the MCOs that, at times, have resulted in delays of payment.
  - Non-Medical Transportation: MCOs handling it differently.
    - Transportation Brokers are unclear about process for getting non-emergency medical and non-medical transportation.
    - Transportation Brokers do not understand how waiver services were working before CHC.
  - Billing coding challenges
  - New Referrals:
    - Some external service coordinators are getting some referrals from MCOs, not through HHA, but by phone or fax.
    - Some providers' referrals originate from service coordinators but providers are told they cannot accept these referrals.
    - Provides may not receive the scope, duration, frequency and proceed with general personal assistance services with the referrals.

Community HealthChoices

SOUTHWEST CONTINUITY OF CARE

SERVICE COORDINATION TRANSITIONS

- UPMC will be offering long-term contracts to ten external service coordinators.
  - UPMC will be evaluating all other service coordination entities on an ongoing basis.
- Pennsylvania Health and Wellness (PHW) will be offering long-term contracts to four external service coordinators.
  - PHW will not be terminating contracts with any other external service coordinator at this time.
- AHC will be developing long-term contracts with more than five service coordination entities.

NETWORK PROVIDERS AFTER CONTINUITY OF CARE

- The CHC-MCOs have not notified DHS of any network provider termination of agreements including:
  - HCBS providers;
  - Nursing facilities; and
  - Physical health providers.
- This includes both in-network and out-of-network providers.

END OF THE CONTINUITY OF CARE

What can participants expect at the end of the continuity of care period?

- A comprehensive needs assessment
- Person-centered service planning
- A revised person-centered service plan

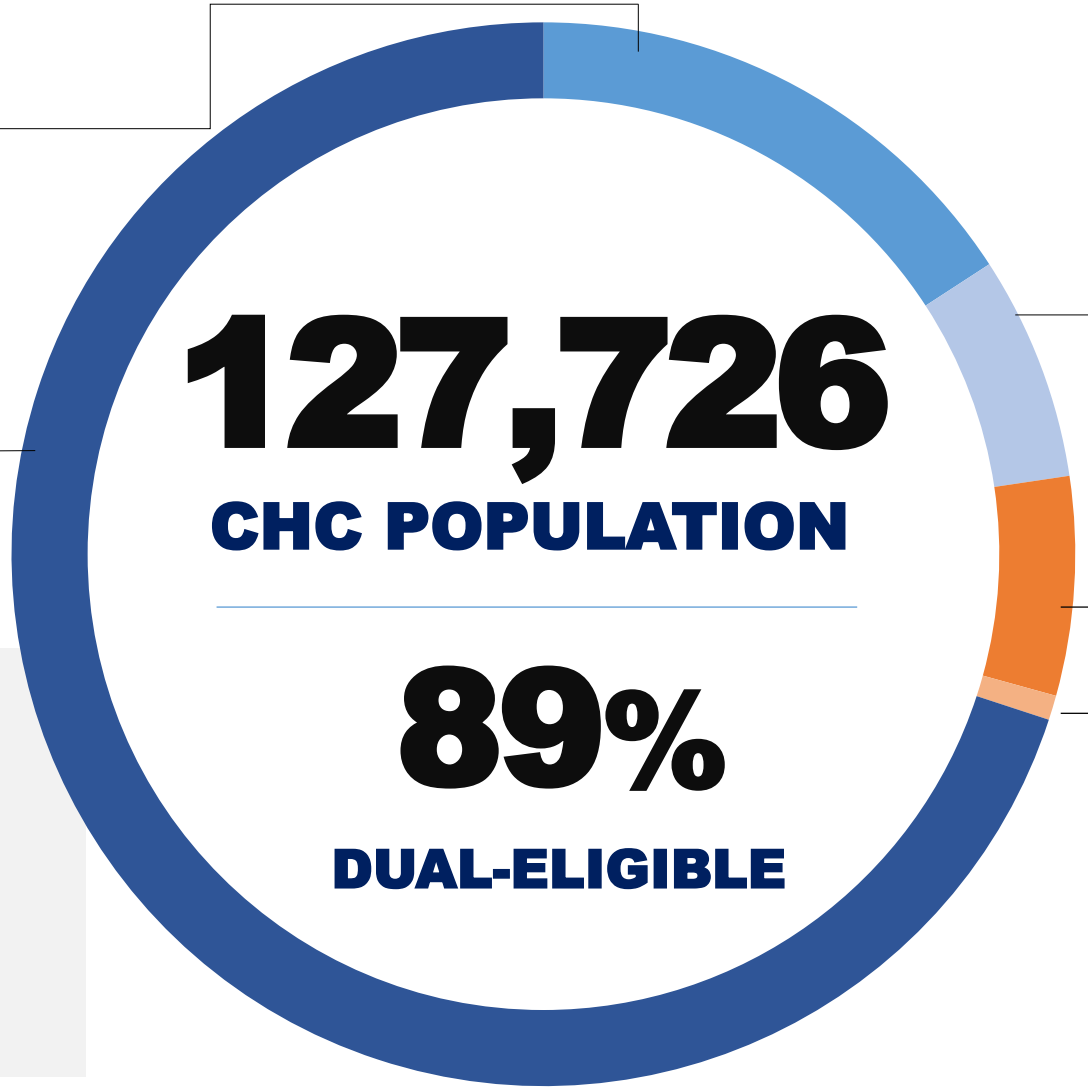
Community HealthChoices

SOUTHEAST IMPLEMENTATION

LESSONS LEARNED

- Earlier stakeholder engagement opportunities
- Enhanced communication materials and training regarding Medicare vs. CHC
- More education and communication on continuity-of-care
- MCO Provider Training and outreach to occur earlier and more often
- Earlier OBRA reassessments
- Earlier data clean-up in HCSIS and SAMS
- Earlier pre-transition notices

CHC SOUTHEAST POPULATION



23%
28,887
Duals in Waivers

56%
72,882
Healthy Duals

10%
12,456
Duals in Nursing Facilities

10%
12,136
Non-duals in Waivers

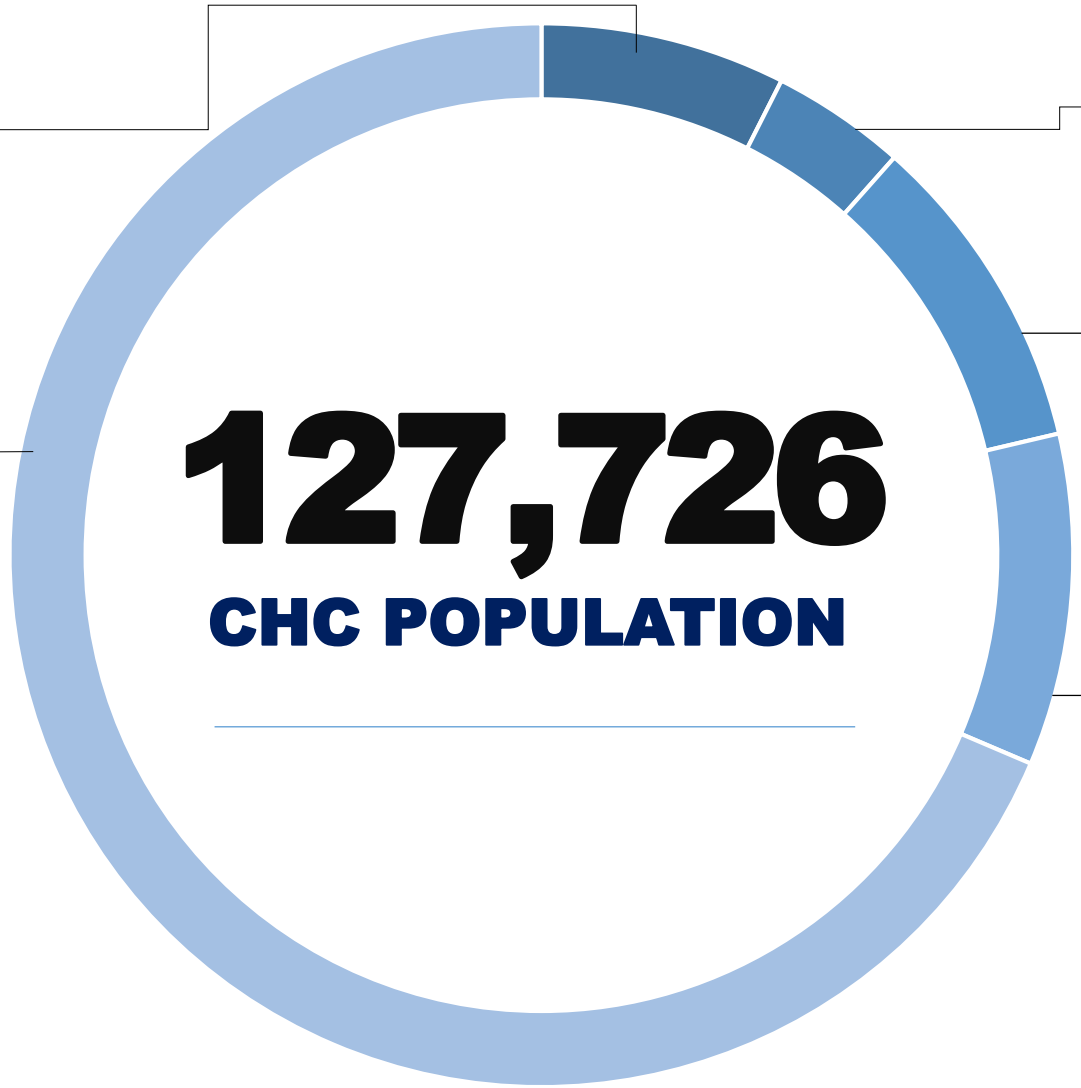
1%
1,365
Non-duals in Nursing Facilities

33%
IN WAIVERS

11%
IN NURSING FACILITIES

Community HealthChoices

CHC SOUTHEAST POPULATION



7%
9,479
Bucks County

4%
5,212
Chester County

69%
87,231
Philadelphia County

10%
12,429
Delaware County

10%
12,826
Montgomery County

SOUTHEAST IMPLEMENTATION FOCUS

- Comprehensive participant communication
- Robust readiness review
- Provider communication and training
- Pre-transition and plan selection for southeast participants
- Incorporation of Southwest implementation and launch lessons learned

SOUTHEAST IMPLEMENTATION FOCUS

- OBRA Assessments
  - Assessments are 94% completed
- Participant Communications Planning
  - An online participant training is being developed from a suggestion made at the MLTSS SubMAAC.
  - Initial touchpoint flyer will be mailed in mid-July.
- Provider Outreach and Education
- Population Identification

PARTICIPANT COMMUNICATION

AWARENESS FLYER

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

AGING WELL EVENTS

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

PRE-TRANSITION NOTICES AND ENROLLMENT PACKET

- Mailed four months prior to implementation. Southeast: August 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

SOUTHEAST COMMUNICATIONS

PROVIDERS

- Provider sessions were held on June 4th through the 8th in Philadelphia and will be held on June 18th to 21st in Chester, Delaware, Montgomery and Bucks counties.
- A webinar for counties will be held July 23.
- Online trainings have been updated.

CHC EVALUATION PLAN

7-YRS OF CHC-EVALUATION PLAN BY THE MEDICAID RESEARCH CENTER AT UNIVERSITY OF PITTSBURGH

Year 1 (Activities)—2017

- **Developed and Designed of Plan** with Stakeholder Input (plan available on CHC website)
- **Key Informant Interviews** (Participants, Caregivers, Providers)
- **Focus Groups w/Participants**
- Participated in **SW Community Events**
- **Implement Surveys**
  - Participants
  - Caregivers
  - Provider Surveys (end of December)
- **Analysis of Administrative Data** (reviewing historical data using Medicaid, Medicare, and NH MDS data)—presentations at upcoming MLTSS meeting

7-YRS OF CHC-EVALUATION PLAN BY THE MEDICAID RESEARCH CENTER AT UNIVERSITY OF PITTSBURGH

Year 2 (Activities)—2018

- **Completed Surveys** (results under review)—presentations at upcoming MLTSS meeting
  - Participants
  - Caregivers
  - Provider Surveys (end of December)
- **Key Informant Interviews** (Participants, Caregivers, Providers)
- Continue **Focus Groups** (SW, SE Participants
- Implement **NH Surveys**
  - Residents
  - NH Providers
- **SW Community Events**
  - Participants
  - Providers
- **Continue Analysis of Administrative Data working closely with OLTL**

Community HealthChoices

RESOURCES

MANAGED CARE ORGANIZATIONS

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

AmeriHealth Caritas Pennsylvania | Keystone First

- www. Keystonefirstchc.com

pa health & wellness

- www.PAHealthWellness.com

UPMC Community HealthChoices

- www.upmchealthplan.com/chc

Community HealthChoices

RESOURCE INFORMATION

CHC LISTSERV // STAY INFORMED http://listserv.dpw.state.pa.us/oltl-community-healthchoices.html

COMMUNITY HEALTHCHOICES WEBSITE www.healthchoices.pa.gov

MLTSS SUBMAAC WEBSITE

www.dhs.pa.gov/communitypartners/informationforadvocatesandstakeholders/mltss/

EMAIL COMMENTS TO: RA-PWCHC@pa.gov

OLTL PROVIDER LINE: 1-800-932-0939

OLTL PARTICIPANT LINE: 1-800-757-5042

INDEPENDENT ENROLLMENT BROKER: 1-844-824-3655 OR (TTY 1-833-254-0690)

(Open Monday through Friday, 8:00 a.m. to 6:00 p.m.)

or visit www.enrollchc.com

Community HealthChoices

QUESTIONS

Community HealthChoices

Working With Your CHC Plan To Get The Supports You Need

June 21, 2018

Presented by:
Pennsylvania Health Law Project

pennsylvania
DEPARTMENT OF HUMAN SERVICES

Disclaimer:

- The following information is provided by the PA Health Law Project and is based on the Community HealthChoices Agreement and other official documents
- However, any advice or suggestions contained herein come from the PA Health Law Project and may not reflect the official positions of the Office of Long Term Living

Acronyms used in this presentation

CHC = Community HealthChoices

MCO = Managed Care Organization:

- AmeriHealth Caritas
- PA Health & Wellness
- UPMC

PCSP = Person Centered Service Plan

Assessment & Person Centered Service Plan

The Assessment

- Assessment Purposes and Uses:
  - Provides important information to service coordinator in developing your service plan ("person-centered service plan").
  - Used by MCO when determining type and amount of services to approve.
- Service coordinator asks questions about how much help you need to do certain tasks.
  - MCOs all use the same basic set of questions.
  - Plus each MCO asks additional questions of their own.
- When answering assessment questions, describe:
  - Help you need, even if you already have help.
  - How long it takes you to do tasks like dressing, bathing, grooming, eating.
  - How much help you need both on good days and bad days.

The Person Centered Service Plan (PCSP)

- Purpose of Person Centered Service Plan
  - Sets out your goals, preferences, and activities that are important to you and supports you need to accomplish them.
  - Provides details on how you will access health care, personal assistance and other services and how much of these services you will get.
- Tell your service coordinator about your goals, preferences and activities that are important to you and the supports you need to accomplish them.
- You can invite others to have input
- Based on the Assessment and input from you and others, service coordinator develops a “person centered service plan” (PCSP)

The Person Centered Service Plan (PCSP)

- After you have had your Assessment and your PCSP is developed, your service coordinator submits it to your MCO.
- Get a copy of your PCSP and read it carefully
  - Your services must be based on your PCSP, so be sure it includes your goals, preferences and important activities and all supports you are looking for. Contact your service coordinator if it doesn't.
  - Contact your MCO if your service coordinator fails to revise your PCSP to include your goals, preferences and important activities

Community HealthChoices

MCO Service Decisions & Notices

Service Decisions

- Your MCO will decide on the type and amount of services to provide you based on your Assessment and PCSP.
- Your MCO may make changes to your services beginning July 1.
  - Changes may include a reduction or termination of one or more of your current waiver services.
- No reduction or termination of services allowed without a completed Assessment and PCSP
- Open & read all mail from your MCO right away
  - You may lose valuable rights if you don't.
  - If you don't understand it, ask your service coordinator.
  - Keep all notices and letters from your MCO & their envelopes

Notices

- If MCO decides to reduce, terminate or change any services you had been getting, they must send you a written Notice
  - If you moved recently, ask your service coordinator to make sure your MCO has your correct mailing address – you must notify the County Assistance Office to change your address
- Notices must be in “accessible formats” for people with visual impairments or limited English
  - If you need notices in an accessible format or another language and instead get a notice you cannot read, your MCO must give you a version in a format or translation you can read if you ask for it.
  - If you ask for notice in a format you can read, the time you have to appeal won’t start until your MCO mails the version of the notice you can read

What the Notices Mean

- Your MCO is planning to reduce one or more of your services If your notice says: “Approved other than as requested”
  - This means your MCO is approving fewer hours of service than you requested or had been getting
- Your MCO is planning to stop one or more of your services if your notice says: “Denied completely because”
- Your MCO is planning to stop one or more of your services but offer a different service if notice says: “A different service or item is approved”

STANDARD DENIAL NOTICE – PARTIAL APPROVAL OF REQUESTED SERVICE/ITEM

[DATE] [This MUST be the date the notice is mailed]

[Participant's Name]
[Address]
[City, State, Zip]

RE: [Participant's name and DOB]

Dear **[Participant Name]:**

[CHC-MCO Name] has reviewed the request for **[identify SPECIFIC service/item/frequency/level/duration]** submitted by **[prescriber's name]** for you on **[date]**. After physician review, the request is:

Approved other than as requested as follows:

[Describe the level, frequency, and duration of service approved.]

[Describe the level, frequency, and duration of service denied.]

The service or item is not approved as requested because: **[Explain in detail at a 6th grade reading level every reason for denial. In addition to explanation for decision, include specific references to approved medical necessity guidelines, rules, or protocols on which the decision is based, in easily understood language. If denied because of insufficient information, identify all additional information needed to render decision.]**

This decision will take effect on [date].

To continue getting services: If you have been getting the service or item that is being reduced, changed, or denied and you file a Complaint or Grievance verbally or that is faxed, postmarked, or hand-delivered **within 10 days of the date on this notice**, the service or item will continue until a decision is made.

STANDARD DENIAL NOTICE – APPROVAL OF DIFFERENT SERVICE

[DATE] [This MUST be the date the notice is mailed]

[Participant's Name]
[Address]
[City, State, Zip]

RE: [Participant's name and DOB]

Dear **[Participant Name]:**

[CHC-MCO] has reviewed the request for **[identify SPECIFIC service/item, along with frequency/level/duration]** submitted by **[prescriber's name]** for you on **[date]**. After physician review, the request is:

Denied as requested, but the following service or item is approved: [Describe the specific service/item approved, including the level, frequency, and duration of service.]

A different service or item is approved because: [Explain in detail at a 6th grade reading level every reason for denial. In addition to explanation for decision, include specific references to approved medical necessity guidelines, rules, or protocols on which the decision is based, in easily understood language. If denied because of insufficient information, identify all additional information needed to render decision.]

This decision will take effect on [date].

To continue getting services: If you have been getting the service or item that is being reduced, changed, or denied and you file a Complaint or Grievance verbally or that is faxed, postmarked, or hand-delivered **within 10 days of the date on this notice**, the service or item will continue until a decision is made.

STANDARD DENIAL NOTICE – COMPLETE DENIAL

[DATE] [This MUST be the date the notice is mailed]

[Participant's Name]
[Address]
[City, State, Zip]

RE: [Participant's name and DOB]

Dear **[Participant Name]:**

[CHC-MCO] has reviewed the request for **[identify SPECIFIC service/item, along with frequency/level/duration]** submitted by **[prescriber's name]** for you on **[date]**. After physician review, the request is:

Denied completely because: [Explain at a 6th grade reading level in detail every reason for denial. In addition to explanation for decision, include specific references to approved medical necessity guidelines, rules, or protocols on which the decision is based, in easily understood language. If denied because of insufficient information, identify all additional information needed to render decision.]

This decision will take effect on [date].

To continue getting services: If you have been getting the service or item that is being reduced, changed, or denied and you file a Complaint or Grievance verbally or that is faxed, postmarked, or hand-delivered **within 10 days of the date on this notice**, the service or item will continue until a decision is made.

Community HealthChoices

Appeals/Grievances

Appeals/Grievances

- What is a Grievance?
  - A request to your MCO that it change its decision to deny, reduce, terminate or change your services.
  - **Grievance** is the name for most appeals to an MCO.
- Who can Request an Appeal/Grievance?
  - The person in CHC who needs the services.
  - A person with a Power of Attorney or guardianship for someone in CHC.
  - A service provider or other person with written permission of the person in CHC.

Filing a Grievance

- How to file a Grievance:
  - Call your MCO, or fax or mail grievance request to the MCO
  - Your MCO must assist you in filing your grievance if you ask
- If you request a Grievance by Phone
  - Ask for and write down the name of the person at the MCO with whom you speak, and date and time of phone call.
  - After you call, send a letter to the MCO confirming your request.

What to Include With Your Grievance

- Some plans include with the decision a form to request a grievance
- No special language to request a grievance, BUT SHOULD:
  - Specify that you want to file a grievance.
  - Explain what you are appealing and why. (Why you disagree with your MCO's decision.)
  - Say you want your services to stay the same while waiting for the grievance decision (if appealing a service reduction or termination).
  - Indicate whether you want to do your grievance by conference call or in person.
    - You have the right to an in-person grievance in a location in the Southwest region convenient for you. CHC grievance panel members must attend in person or by videoconferencing.
    - Even if you are in-person, your witnesses can call in.

Time to File Grievance

- To keep the same amount of services while your appeal/grievance is pending, you must tell your MCO you want to appeal by the later of:
  - Date listed on the notice where it says: “This decision will take effect on …” or
  - Within 10 days from date of mailing (keep envelope for the postmark).
- Grievances can be made up to 60 days after the date of the Notice of Denial, Reduction or Termination of services.
  - BUT if the grievance is filed after the effective date of the reduction or termination listed on the Notice, services may not continue while the grievance is pending.
- Filing a grievance about denial of a new service or a service increase doesn’t get you the service while waiting for the grievance decision.

What Happens Next?

- You receive a “Grievance Acknowledgment Letter” stating why you filed a grievance and when your MCO received it.
  - If the Grievance Acknowledgment Letter doesn’t accurately describe the reasons for your grievance, call the number on the letter to clarify.
- If the grievance is made before the effective date of the reduction/termination on the Notice, your services will continue while your appeal/grievance is pending.

What Should You Do Next?

- Contact Pennsylvania Health Law Project (800-274-3258) for free advice.
- Ask your MCO's Appeals/Grievance unit for:
  - "All relevant documentation pertaining to the subject of the Grievance" - It's your right and must be provided free of charge.
  - Copies of any "time for task" guidelines and any other tools or guidelines used by your MCO to decide how much service they authorized.
- If you don't have a copy of your person centered service plan, ask you service coordinator for a copy- it's your right and must be provided free of charge.

Preparing for the Grievance

- The PA Health Law Project will present another webinar this month on how to prepare for the grievance meeting and what information you should submit.
- Visit us at www.phlp.org for the date and how to register
- The PA Health Law Project will try to provide free legal advice to people in CHC who have filed grievances to the extent we have staff available- contact us at 1-800-274-3258 on Mondays, Wednesdays or Fridays

When will the MCO decide my grievance/appeal?

- Regular Decision Process – decision takes up to 30 days.
- Expedited Grievance Process – decision within 3 days.
  - Must provide a signed “certification” from your service provider or physician that your “life, physical or mental health, or ability to attain, maintain, or regain maximum function would be placed in jeopardy by following the regular Grievance process.”

What if I disagree with the grievance decision?

- Two options for further appeals
  - Fair Hearing and/or
  - External Review
- If your services were continuing while your grievance was pending and you lost your grievance, you must file the next appeal within 10 days of the date the grievance decision was mailed. Otherwise your services will be reduced or stopped.

QUESTIONS