Community HealthChoices

HCBS PROVIDER OVERVIEW

Southeast Provider Summit

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pennsylvania
DEPARTMENT OF HUMAN SERVICES

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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 personal assistance services (PAS) and meet the needs of the participants.
- The CHC-MCOs are asking PAS 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.

Lesson Learned: Hold webinar(s) for participants and providers on how to use the IEB provider directory search tool.

NETWORK ADEQUACY

OLTL MONITORING

- The commonwealth will conduct ongoing monitoring to ensure the CHC-MCOs maintain provider networks that enable participants to have a choice of provider for needed services.
- MCOs must submit a Provider Network report that contains a comprehensive file of all network providers with a breakdown of each PAS provider's FTEs.
- Network file to be submitted weekly for OLTL provider network analysis (used to update the OLTL Network Analysis tool on a monthly basis) and to the IEB for its Provider Directory.
- Provider Network report also to be submitted annually to OLTL.

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 who resides in a nursing facility on the implementation date will be able to stay in the nursing facility as long as the participant needs this level of care, unless the participant chooses to move.

Lesson Learned: Earlier communication and information sessions for participants and providers were needed on continuity of care and other issues, such as switching plans, network evaluation and problem resolution.

STANDARDS AND PROTECTIONS FOR CONTINUITY OF CARE

- The CHC-MCO must notify OLTL in writing of its intent to terminate a Network Provider and services provided by a Network Provider, **90 days prior to the effective date of the termination.**
- The CHC-MCO must have procedures to address changes in its Provider Network that impact participant access to services.
- The CHC-MCO is required to provide written notice to the participant **45 days prior to the effective date of the Provider's termination.**
- The CHC-MCO is required to provide written notice of any change to a participant's service plan with information on complaints, grievances, and appeals processes.
- OLTL will monitor the CHC-MCOs notification requirements.

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

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

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PROCESS TO BEGIN CHC ELIGIBILITY AND SERVICE PROVISION

Lessons Learned:

- A better tracking process is needed for newly enrolled FFS HCBS participants who are in process or who enter the system between the dates the transition file is generated and go live to ensure that MCOs have up-to-date data.
- Data cleanup needed to ensure that correct eligibility files are used and correct populations are being enrolled in CHC.
- Indicators should be used to distinguish new enrollment from plan transfers during launch.
- Make paper enrollment forms available at participant information sessions.
- Online enrollment form should include plan choice.

PROCESS FOR ELIGIBILITY AND SERVICE REDETERMINATION

COUNTY ASSISTANCE OFFICE

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

CHC-MCO

- Completes the redetermination using questions from Pennsylvania Individualized Assessment (PIA) tool, plus additional questions unique to the MCO
- Transmits data to DHS
- Updates the Person-Centered Service Plan

DHS

- PIA data from CHC-MCO populates InterRAI HC tool and generates a preliminary NFCE or NFI designation
- DHS transfers PIA/InterRAI HC tool and results to Aging Well

AGING WELL

- Validates the annual redetermination process was completed by CHC-MCO and conducted correctly
- DHS makes final eligibility determination of continuing eligibility based on Aging Well review.
- Aging Well transmits final determination to CHC-MCO.

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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.
- Sign up for the CHC LISTSERV by going to www.healthchoices.pa.gov and click "Provider Resources" and "Community HealthChoices".

PROVIDER ENROLLMENT

HOW DO PROVIDERS ENROLL WITH A CHC-MCO?

- A CHC-MCO provider must be enrolled in the Pennsylvania Medical Assistance (MA) Program and must be credentialed by and contracted with a CHC-MCO to receive reimbursement to a CHC participant.
  - The MA enrollment process verifies a provider meets MA enrollment requirements.
  - Providers must be enrolled in MA for all types of services they wish to provide under CHC.
  - To meet necessary accreditation standards, CHC-MCOs must have their own provider credentialing 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 ENROLLMENT

HOW DO PROVIDERS ENROLL WITH A CHC-MCO?

- 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 Southeast 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.
- All three CHC-MCOs are using HHA Exchange for providers to bill for home health and personal assistance services.

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, 2019 to be eligible to contract with CHC-MCOs in the SE zone.

MANAGED CARE ORGANIZATIONS

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

Keystone First / AmeriHealth Caritas Pennsylvania — CHCProviders@keystonefirstCHC.com

pa health & wellness — information@pahealthwellness.com

UPMC Community HealthChoices — CHCProviders@UPMC.edu

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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.

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/

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THIRD PARTY LIABILITY

HOW IS THIRD PARTY LIABILITY HANDLED WITH CHC?

- Providers are required to check the 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.

Lessons Learned: Clear materials and training needed on how CHC interfaces with Medicare (for MCOs, providers and participants). Training needed for MCOs on understanding Medicare/Medicaid certification and survey compliance. Additional training for County Assistance Offices needed on TPL.

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 (EIM) System.
- CHC-MCOs must ensure that providers are trained on the use of EIM.
- 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, employment 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.

Lessons Learned: Periodic emails needed to clarify the roles of care and service coordinators in CHC. Earlier training of service coordinators by the MCOs needed on their roles. Testing was needed to address SAMS and HCSIS issues.

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COORDINATION WITH MEDICARE

HOW DOES CHC IMPACT A PARTICIPANT'S MEDICARE?

- Dually eligible participants will continue to have all of the Medicare options they have today, including Original Medicare and Medicare Advantage managed care plans. The implementation of CHC will not change the services that are covered by Medicare.

- All CHC-MCOs are required to offer a companion Dual Eligible Special Needs Plans, also known as D-SNPs to its dually eligible participants. D-SNPs are a type of Medicare Advantage plan that coordinates Medicare and Medicaid services.

COORDINATION WITH MEDICARE

- Medicare will continue to be the primary payor for any service covered by Medicare. Providers will continue to bill Medicare for eligible services prior to billing Medicaid. All Medicaid bills for participants will be submitted to the participant's CHC-MCO, including bills that are submitted after Medicare has denied or paid part of a claim.

- Participants must have access to Medicare services from the Medicare provider of his or her choice. The CHC-MCO is responsible to pay any Medicare co-insurance and deductible amount, whether or not the Medicare provider is included in the CHC-MCO's provider network.

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.

CARE AND SERVICE COORDINATION IN CHC

WHAT HAPPENS WITH SERVICE COORDINATION AT THE END OF CONTINUITY OF CARE?

- 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.
- CHC-MCOs must report to OLTL on service plan changes, missed services, denial notices, and complaints and grievances during and after the continuity of care period. OLTL will monitor these reports and address concerns with the CHC-MCO.

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.

Lessons Learned: MCOs need to get providers set up and trained by HHA sooner. Data cleanup needed to eliminate discrepancies between SAMS and HCSIS records. Preparation of continuity of care files for those moving to CHC from HC should begin earlier.

CARE AND SERVICE COORDINATION IN CHC

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

- A CHC-MCO must provide an electronic or hard paper copy of a participant's existing Comprehensive Medical and Service Record, including PCSPs, to the participant's new CHC-MCO within 5 business days of the participant's notification of the transfer.

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 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 are subject to the 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.
- OLTL and CHC-MCOs are working together to determine a process to ensure that home modifications that are in process prior to CHC implementation are completed.

SPECIFIC CHC SERVICES

HOW WILL CHC-MCOS HANDLE TRANSPORTATION?

- CHC participants have access to non-emergency medical transportation to medical appointments.
- NFCE participants also have access to non-medical transportation.
- MATP is to be used for non-emergency medical transportation.
- Participants in nursing facilities are the exception – nursing facilities will continue to coordinate transportation for their residents.

SPECIFIC CHC SERVICES
HOW WILL CHC-MCOS HANDLE TRANSPORTATION?

Population	Emergency Medical		Non-Emergency Medical		Non-Medical	
	Payment	Coordination	Payment	Coordination	Payment	Coordination
NFCE – HCBS Waiver	CHC-MCO	CHC-MCO/ Participant	MATP - Non-Ambulance & Unexceptional CHC-MCO – Ambulance/Specialized/ Stretcher CAO Medical Transportation Allowance - Exceptional	CHC-MCO/ Participant	CHC-MCO	CHC-MCO/ Participant
NFI Dual	CHC-MCO	CHC-MCO/ Participant	MATP – Non-Ambulance & Unexceptional CHC-MCO – Ambulance/Specialized/ Stretcher CAO Medical Transportation Allowance - Exceptional	CHC-MCO/ Participant	Not a covered service under CHC. CHC-MCO may provide non-medical transportation to participants at its own discretion and own cost.	CHC-MCO/ Participant

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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 receiving HCBS.
- 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?

- Financial Management Services (FMS) will continue.
- The CHC-MCOs are required to establish agreements and cooperate with the Commonwealth-procured Fiscal/Employer Agent (F/EA) in order that necessary FMS services are provided to participants.
- The F/EA will continue to perform 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
  - Generate reports for participants, CHC-MCOs and OLTL
- Have resolved file exchange issues between PPL and CHC-MCOs during Southwest implementation

Lessons Learned: MCOs need to get providers set up and trained by HHA sooner. Data cleanup needed to eliminate discrepancies between SAMS and HCSIS records. Preparation of continuity of care files for those moving to CHC from HC should begin earlier.

SPECIFIC CHC SERVICES

HOW WILL CHC-MCOs HANDLE NURSING HOME TRANSITIONS?

- CHC-MCOs must provide nursing home transition (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.
- CHC-MCOs will ensure that nursing facility residents receive information about transition options and assistance with initiating and completing transition.
- 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.

Lessons Learned: NHT process education should be included as part of provider training.

SPECIFIC CHC SERVICES

HOW WILL CHC-MCOS HANDLE NURSING HOME TRANSITIONS?

- An applicant in a nursing facility who is not enrolled with a CHC-MCO who has applied for long-term care MA coverage – but has not yet been approved by the CAO – may request NHT services. For an applicant who is not yet enrolled in CHC:
    - The nursing facility staff will follow referral procedures established for fee-for-service NHT.
    - The NHT Coordination Agency chosen by the Applicant will carry out NHT activities and follow procedures established for fee-for-service NHT.
    - The CHC-MCO is not required to interact with the Applicant until he/she is found eligible for CHC and a CHC plan is selected.

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 solicited input from participants, 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 received 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.
- The Department will use an open system, so providers with existing systems will be able to share their data with the state system.
- The Department is in the process of working with stakeholders to develop EVV policies and implement by January 2019.

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.

Lesson Learned: Systems training by the MCOs should be provided earlier to service coordinators and providers.

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.

Lesson Learned: THE LIFE Program needs to be marketed not just at enrollment but throughout the educational outreach phase.

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-MCOs must coordinate with the Act 150 program.
- The Quality Management Efficiency Teams (QMETs) will continue to monitor Act 150 providers.

OLTL MONITORING

HOW WILL OLTL MONITOR MISSED SERVICES AND CHANGES TO PERSON-CENTERED SERVICE PLANS?

- OLTL has developed report requirements to capture service plan changes, missed services, 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.
- HCBS providers are required to provide information on missed services 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 SCEs and HCBS providers to assist in responding to OLTL requests.

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ESTABLISHED STATEWIDE QUALITY STRATEGY PLAN

STAKEHOLDER 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
  - Person-Centered Planning Process
- 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

QUALITY MEASURES

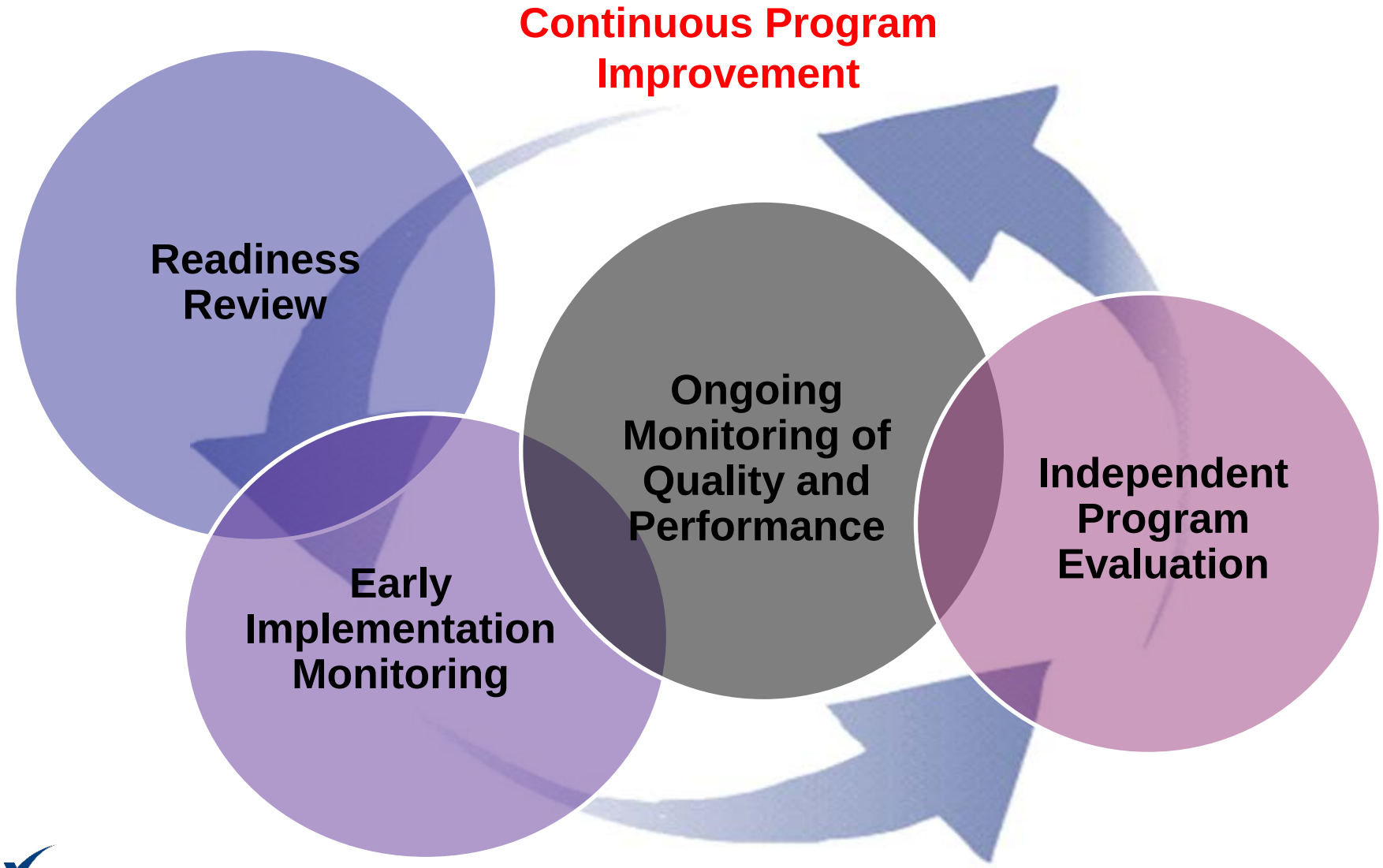
Comprehensive list of *proposed* measures

National	State	Launch Indicators

• 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
	• LTSS Community Based Services
	• Service Coordination and Care Coordination
	• Grievances, Appeals & Critical Incidents
	• Rebalancing
	• CHC HCBS Waiver Assurances
		• Key data points provided frequently during launch
		• Focus on:
		  • Continuity of Services
		  • LTSS Provider Participation

Lesson Learned: For monitoring and quality purposes, program priorities should be articulated for each phase – readiness, launch and steady state.

Key Components of Quality Assurances & Improvements



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	Pre-Launch	Launch (Begins at "Go Live")	Steady State (9-12 Mos. & Beyond)
Primary Aim	Readiness	Continuity	Program Improvement
Key Activities	Readiness Reviews System Testing Baseline Analyses	Frequent Meetings with MCOs Monitor Launch Indicators & Reports Implement Monitoring Reports	Regular Meetings with MCOs Quarterly Quality Reviews Conduct Evaluation Analyses Analyze Monitoring Reports
Tools	Readiness Review Tool Report Templates Quality Strategy	Launch Indicators Process Measures Hot-lines (Consumer & Provider) Monitoring Reports	Outcome Measures Monitoring Reports Program Imp. Projects (PIPs) Pay for Performance (P4Ps)
Stake-holders	Consumer Communications Provider Communications Local Advisory group SubMAAC, 3rd Thurs. CHC Website	MCO Participant Advisory Coms. SubMAAC, 3rd Thurs. CHC Website	MCO Participant Advisory Coms. Ad Hoc Public Engagements SubMAAC, 3rd Thurs CHC Website

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COMMUNICATIONS

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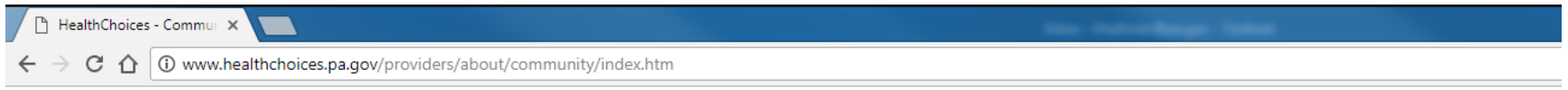

TRAINING

These trainings have been created to help providers answer questions about CHC.
CHC Overview Training (Approx. 30 minutes)

Direct Service Providers
Direct Service Provider Online Course (Approx. 45 minutes)

Service Coordinators
- For the general public - Service Coordination Online Course (Approx. 45 minutes)
- For service coordinators only, visit the following website for instructions on how to complete the training which includes a test to verify competency.

Nursing Facilities
- For the general public - Nursing Facility Training (Approx. 40 minutes)
- For nursing facilities only, visit the following website for instructions on how to complete the training.
- Nursing Facility Eligibility and Enrollment Process webinar | powerpoint

PROVIDER DOCUMENTS

General
CHC Acronym Glossary Guide
What is CHC?
Who is served by CHC?
Community HealthChoices vs. HealthChoices
Informational flyer
Timeline for Implementation
Provider Eligibility

Benefits/Service Coordination
Service Coordination
Continuity of Care
Long-Term Services Guide
Adult Benefits Package
Behavioral Health Provider Update
Coordination with Medicare

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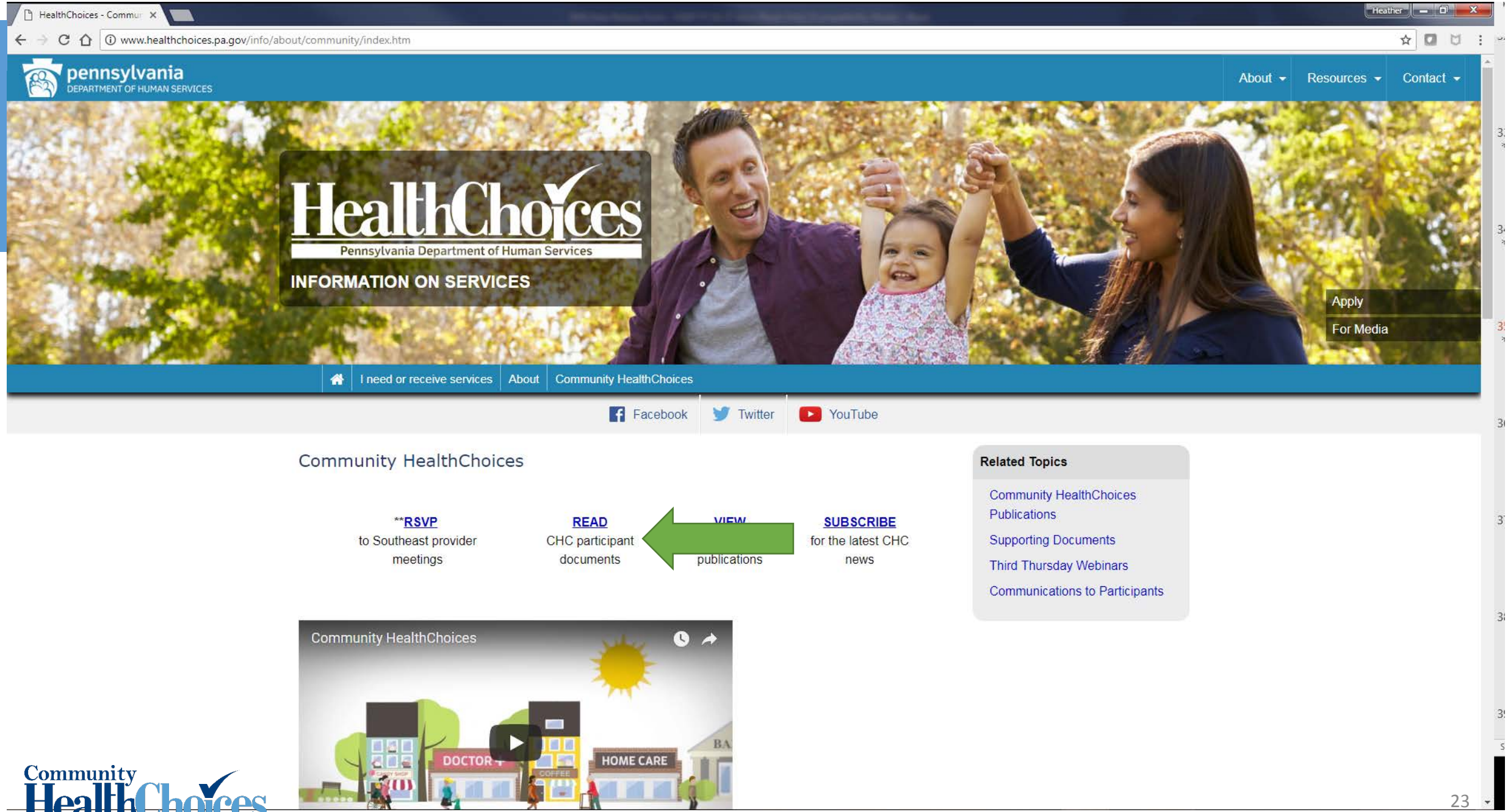
PROVIDERS

- Bi-weekly email blasts on specific topics
  - ✓ Examples: Billing, Service Coordination, Medicare, HealthChoices vs. CHC, Continuity of Care
- Provider narrated training segments
- Provider events in local areas to meet with MCOs and gain information about CHC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DEPARTMENT OF HUMAN SERVICES
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Supporting Documents
Third Thursday Webinars
Communications to Participants
Community HealthChoices
DOCTOR
HOME CARE

PARTICIPANTS

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

COMMUNICATIONS

Lessons Learned:

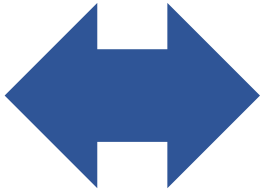
- There should be more outreach online via social media.
- Associations should be used more to reach providers.
- DHS should continue provider sessions and offer more
- DHS improved the CHC website.

PARTICIPANTS

COMPARISON OF FFS VS. MANAGED CARE

FEE-FOR-SERVICE

- Provide necessary documentation to the Department
- Contact a service coordination entity to coordinate services
- Receive service from a provider



MANAGED CARE

- Provide necessary documentation to the Department
- Enroll in a MCO and work with the MCO to coordinate and receive necessary services
- Receive services from a provider

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 CHC-MCOs.

WHAT IS NECESSARY?

- Select an MCO by the date indicated by the Department.
  - ✓ Get information on the different plans by going to www.enrollCHC.com.
- Educate yourself.
  - ✓ Participate in CHC Third Thursday webinars to learn more about CHC.
  - ✓ Participate in stakeholder engagements.
  - ✓ Read CHC-related information sent to you by the Department.
  - ✓ Participate in upcoming educational sessions hosted by Aging Well.

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.

Community HealthChoices

PROVIDERS

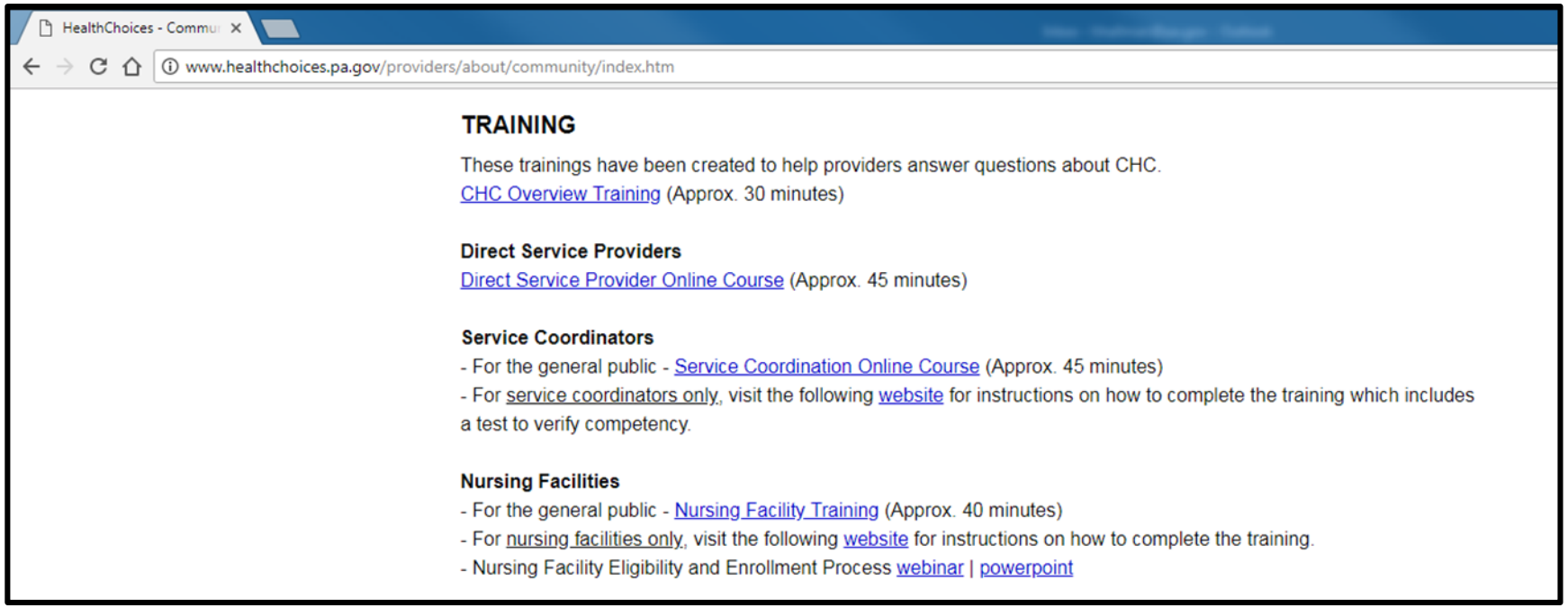
WHAT IS NECESSARY?

- Contact MCOs to discuss contracting.
  - ✓ All providers will need to contract with the MCOs to provide services through the continuity of care period.
- Educate yourself.
  - ✓ 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.

RESOURCES

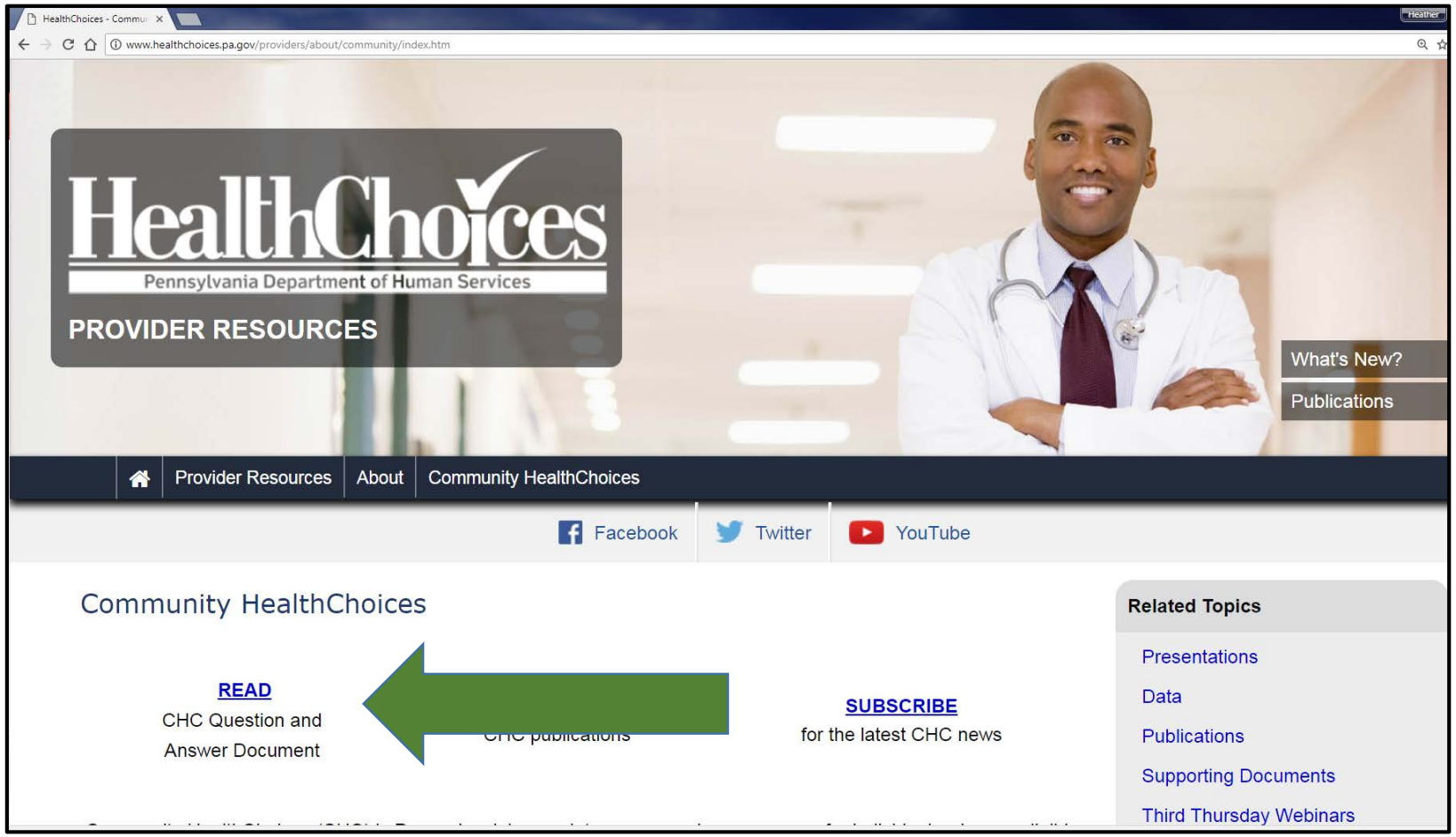
CHC Trainings

- CHC trainings are available on the DHS website at www.healthchoices.pa.gov.
- Click “Provider Resources” and then “Community HealthChoices”.
- From the Community HealthChoices page, scroll down to TRAINING.



CHC Question and Answer Document

- CHC question and answer document is available on www.healthchoices.pa.gov.
- Click “Provider Resources” and then “Community HealthChoices”.
- Includes provider and participant related questions and answers organized by topics.



RESOURCE INFORMATION

WEBSITE LINKS:

COMMUNITY HEALTHCHOICES WEBSITE

www.healthchoices.pa.gov

CHC Question and Answer Document

http://www.healthchoices.pa.gov/cs/groups/webcontent/documents/document/c_274784.pdf

MLTSS SUBMAAC WEBSITE

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

CHC LISTSERV // STAY INFORMED

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

RESOURCE INFORMATION

CONTACT INFORMATION

EMAIL COMMENTS TO: RA-MLTSS@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

CHC MCO Contact Information

Keystone First/AmeriHealth Caritas | CHCProviders@keystonefirstCHC.com
www.Keystonefirstchc.com - 1-855-235-5115 (TTY 1-855-235-5112)

Pennsylvania Health and Wellness (Centene) | information@pahealthwellness.com
www.PAHealthWellness.com – 1-844-626-6813 (TTY 1-844-349-8916)

UPMC Community HealthChoices | CHCProviders@UPMC.edu
www.upmchealthplan.com/chc - 1-844-833-0523 (TTY 1-866-407-8762)

CONTACT US

EMAIL COMMENTS TO: RA-PWCHC@pa.gov

OLTL PROVIDER LINE: 1-800-932-0939

OLTL PARTICIPANT LINE: 1-800-757-5042

QUESTIONS