Community HealthChoices

O V E R V I E W

Community HealthChoices
Southeast Provider Summit
Nursing Facility Providers

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pennsylvania
DEPARTMENT OF HUMAN SERVICES

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 (DHS) 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
  - Preadmission Screening and Resident Review
  - Medical Assistance (MA) billing until CHC start date

Any Willing Provider

Each CHC managed care organization (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 DHS and the CHC-MCO
- For Phase II (SE Zone): January 1, 2019 – June 30, 2020

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, a 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 not eligible 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 – Provider is being terminated for cause as described in 40 P.S. § 991.2117(b).

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Payment for NF Services

NF resident moves from HealthChoices (HC) to CHC

- HC-MCO will pay for 30 days as a physical health benefit
- HC-MCO will pay for day 31 through the date the eligibility determination is made if resident is found functionally and financially eligible by the CAO to receive NF services
- CHC-MCO will pay beginning the day after 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
- CHC-MCO will pay beginning the day after eligibility is determined

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Payment for NF Services

CHC Community Participant Needs NF Services

- CHC-MCO will pay for 30 days (including hospital reserve bed days and therapeutic leave days) as a physical health benefit.

- Once the participant is found eligible for long-term care services, 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
- Southeast – Calendar Year 2018 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 DHS and each CHC-MCO (relating to nursing facility 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.

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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.
- DHS 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

- CHC-MCOs must provide medically necessary emergency ambulance transportation, non-emergency medical transportation and non-medical transportation for NF residents.

- CHC-MCOs, through their service coordinators, are responsible for coordinating transportation for their Participants.

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 get feedback regarding appropriate claims submission practices

CHC-MCOs must operate provider services functions during regular business hours, including assisting providers with claims payment issues.

Lessons Learned – NFs & MCOs should start claims testing now. There is no need to wait until there is a signed contract.

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 DHS.

Claims

Dispute Resolution

- CHC-MCOs will handle disputes regarding claims submission and payment reconciliation.
- Information of 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 Office of Long-Term Living (OLTL) for review.
- 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.

Service Coordination

- Every participant receiving LTSS will choose a service coordinator. 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 healthcare, long-term services and supports (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 healthcare, LTSS, and wellness needs and preferences.

Lessons Learned – Clarify that SC's role in a NF is to assist the NF staff with the resident's care plan, service provisions, NHT services and any other related needs. The SC is the NF's point of entry for provision of services.

Service Coordination

- The CHC-MCO must conduct needs assessments according to the agreement with DHS; they will use the Minimum Data Set or MDS instead of 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.

Coordination

Medicare and Medicare Providers

- Dually eligible participants will continue to have all of the Medicare options they have today. Their Medicare will not change unless they decide to change it.
- Medicare will continue to be the primary payor for any service covered by Medicare.
- If a NF resident is dually eligible, they may choose a Medicare provider instead of a provider in their CHC-MCO's network.

Service Coordination

Nursing Home Transition (NHT)

- 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.
- NF, MCO SC & NHT entity will work together to coordinate all necessary services for transition.

Lessons Learned – Provide more training to NFs and change timing for eligibility determination.

Service Coordination

Behavioral Health

- All CHC participants will be covered by behavioral health (BH) managed care through the existing BH-MCOs.
  - Similar to PH-MCOs and CHCs, BH-MCOs establish provider networks
  - CHC Participants are:
    - Auto-enrolled in a BH-MCO based on county of residence
    - Offered a choice of BH providers within the BH-MCO
    - Eligible to receive covered services through assigned BH-MCO
- Behavioral health is a component of the PCSP.

- CHC-MCOs will have a BH coordinator to monitor for compliance with the agreement and coordinate participant care needs with BH-MCOs.

Service Coordination

Behavioral Health

The CHC-MCO BH coordinator is a BH professional located in PA who:

- Is knowledgeable of the BH Managed Care Agreement and coordinates with the BH-MCOs to carry out the requirements
- Coordinates participants care needs with BH providers
- Coordinates behavioral care with medically necessary physical health services
- Primary Care:
  - Identifies best practices for BH in a primary care setting
  - Develops processes to coordinate BH care between primary care practitioners and BH providers

Lessons Learned – Additional education from BH-MCOs & CHC-MCOs

BH-MCOs

Community Care Behavioral Health

CCBH- Chester

Community Behavioral Health

CBH – Philadelphia

Magellan Behavioral Health

MBH –Bucks, Delaware and Montgomery

BH Services

State Plan Services

- Clozaril Support
- Methadone Maintenance
- Drug and Alcohol Outpatient
- Inpatient Psychiatric Hospital
- Inpatient Drug and Alcohol Detox and Rehabilitation
- Outpatient Psychiatric Clinic
- Psychiatric Partial Hospitalization
- Peer Support Services
- Mental Health Targeted Case Management (intensive case management, resource coordination, blended)
- Laboratory and Diagnostic Services
- Tobacco Cessation Counseling Services
- Mental Health Crisis Intervention

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BH Services

Supplemental

Additionally, the BH-MCOs may provide medically necessary and cost effective alternatives to State Plan Services approved by Office of Mental Health and Substance Abuse Services (OMHSAS). The most commonly approved services include:

- Non-Hospital Drug and Alcohol Detoxification and Rehabilitation
- Certified Recovery Specialist
- Halfway House
- Psychiatric Rehabilitation Services
- Mobile Medication
- Licensed Psychologist, LSW, LPC
- Assertive Community Treatment Teams (ACT)

Communications

For Participants

August 2018

- Pre-transition notices and CHC enrollment information sent to SE participants
- Letter instructs participants that the Independent Enrollment Broker will send them information about selecting a CHC-MCO.

August to October 2018

- Aging Well Sessions for Participants

September to November 2018

- SE participants will select their plan

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

Independent Enrollment Broker (IEB)

NF & IEB Interaction:

NF may make referral to IEB.

IEB works with NF to schedule and conduct phone consultation for plan counseling with POA, Spouse, etc. within 5 business days if not already enrolled in CHC.

See *CHC Related Nursing Facility Eligibility and Enrollment Process Flows (*Slide 34) for more information.

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

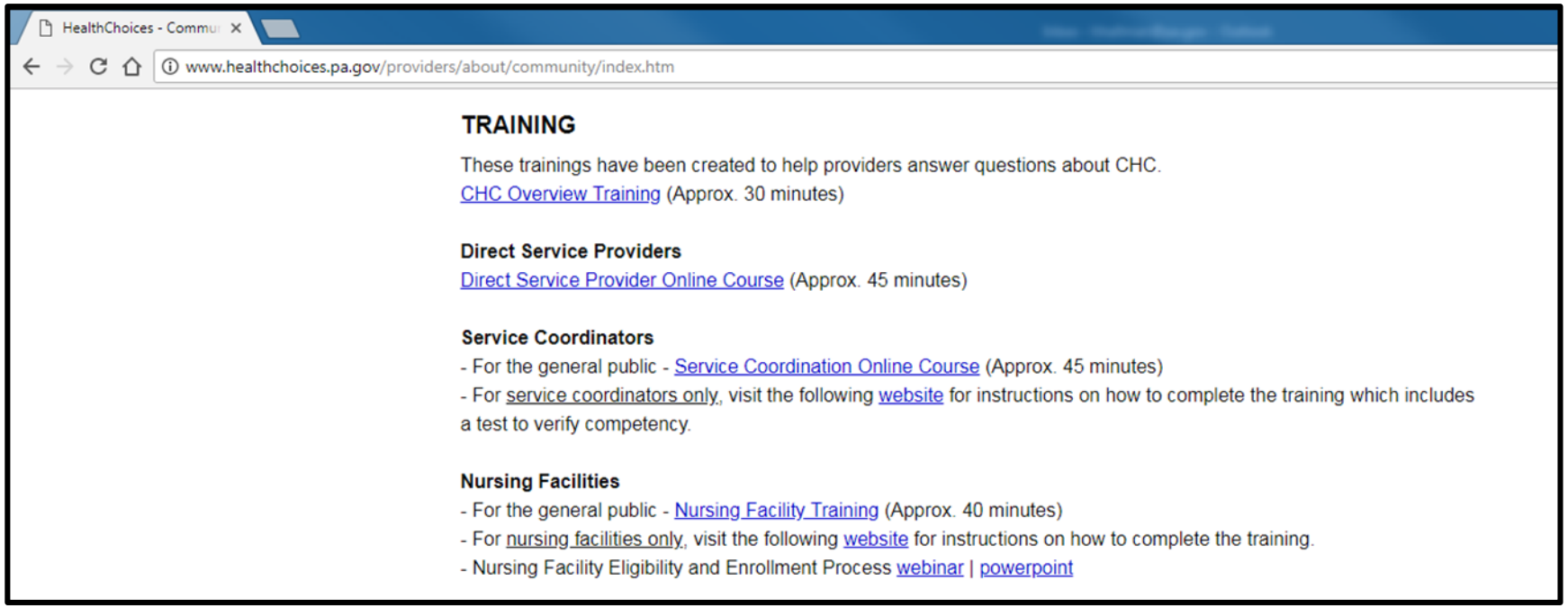
Termination by Network Provider

When a CHC-MCO terminates a network provider or 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 DHS in writing 90 days in advance
- submit to DHS 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

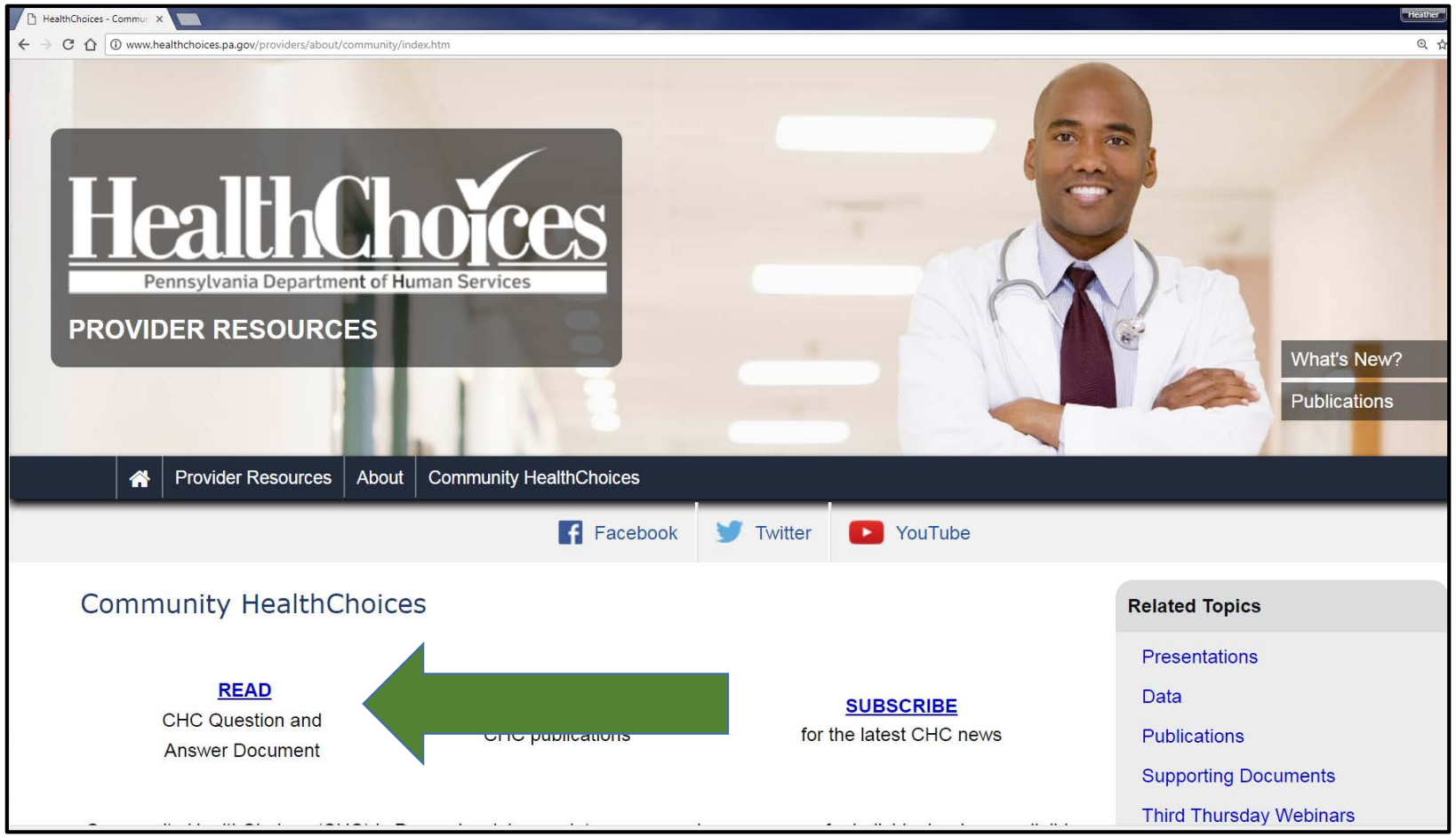
CHC Trainings

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



CHC MCO Contact Information

- Keystone First | 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)

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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)
or visit www.enrollchc.com

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QUESTIONS