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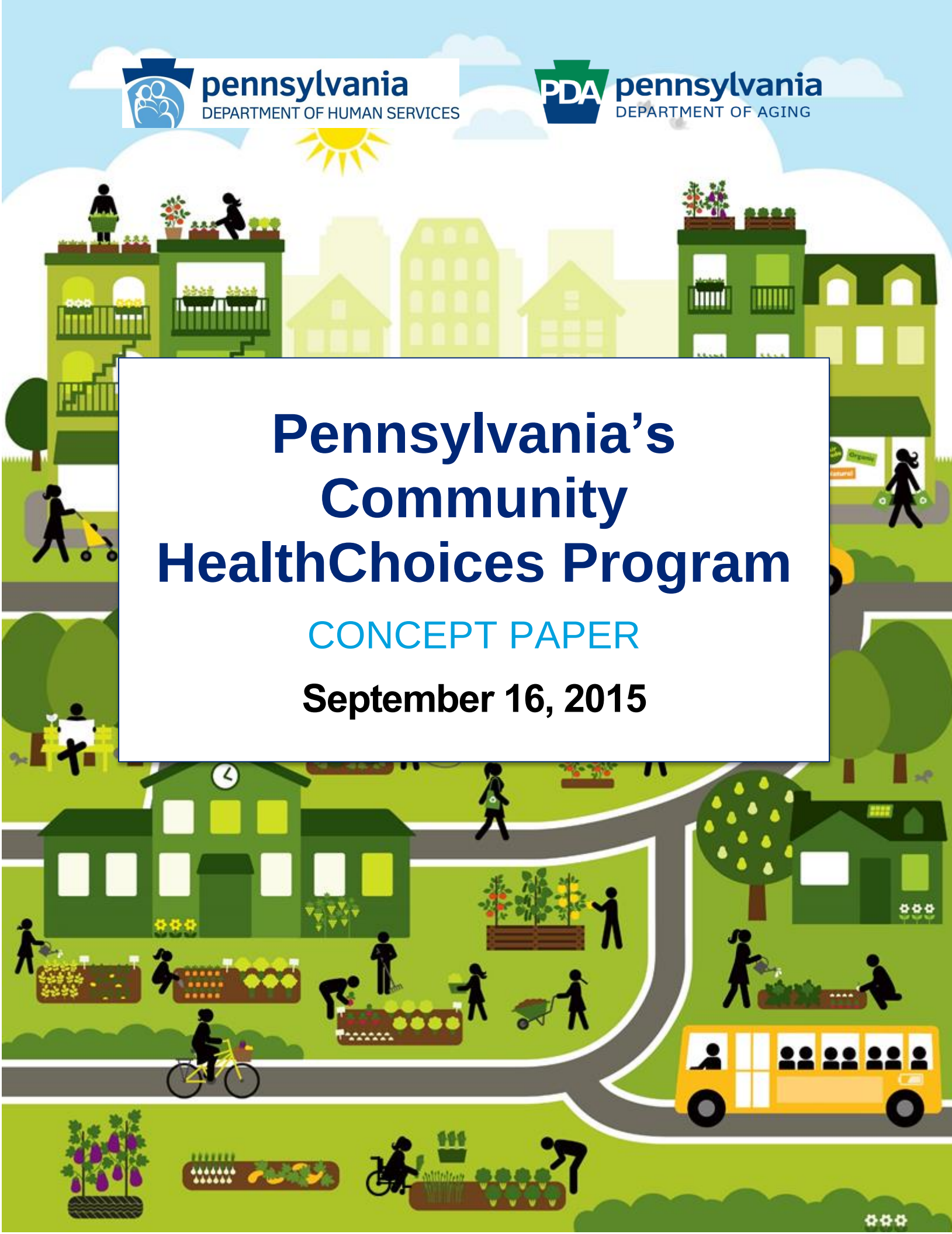

Pennsylvania's Community HealthChoices Program

CONCEPT PAPER

September 16, 2015

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Your feedback is requested.

This document contains the commonwealth's design for Community HealthChoices (CHC). The commonwealth invites feedback on this document from participants, advocacy organizations, providers, managed care organizations, care coordination agencies, legislators, family members, and other interested members of the public. Feedback received will be used to finalize the program design and issue a Request for Proposals (RFP) in November 2015.

Feedback is due by 5:00 p.m. on Friday, October 16, 2015.

Please submit your written feedback by mail or e-mail.

By mail, please address to:

April Leonhard
Office of Long-Term Living
Bureau of Policy and Regulatory Management
P.O. Box 8025
Harrisburg, PA 17105-8025

By e-mail, please send your comments to:

RA-MLTSS@pa.gov and include "Community HealthChoices" in the subject line.

This document is available in alternative formats.

To request an alternative format, please call the Department of Human Services, Office of Long-Term Living at (717) 783-8412.

Persons with a disability who require an auxiliary aid or service may submit comments using the Pennsylvania AT&T Relay Service at (800) 654-5984 (TDD users) or (800) 654-5988 (voice users).

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1. Introduction

Under Governor Tom Wolf's leadership, the Pennsylvania Departments of Human Services (DHS) and Aging (PDA) are developing a new program for older Pennsylvanians and adults with physical disabilities called Community HealthChoices (CHC). The program will roll out in three phases over three years, beginning in January 2017.

Highlights

- Summary of CHC Program
- Background
- Program Vision & Goals

As described in this concept paper, the commonwealth is committed to creating a system that allows Pennsylvanians to receive services in the community, preserves consumer choice, and allows consumers to have an active voice in the services they receive.

This concept paper describes the features of CHC and is intended to gather feedback from stakeholders.

The commonwealth chose the name Community HealthChoices for two reasons. The first is that CHC will allow the commonwealth to serve more Pennsylvanians who need long-term services and supports in the community. The second is that CHC will build on the values and processes of the HealthChoices program that has successfully served millions of Pennsylvanians since its inception in 1997. In fact, many of the tenets of the program described below mirror the processes that have proved to be successful in the HealthChoices program.

1.1 Summary of CHC

The commonwealth plans to coordinate health and long-term services and supports (LTSS) through CHC managed care organizations (CHC-MCOs). Participants will have a choice of two and five CHC-MCOs in each region. The CHC rate model will include value-based incentives to increase the use of home and community-based services (HCBS) and meet other program goals. CHC will use standardized outcome measures at both the program- and participant-level to assess overall program performance and improve the CHC program over time.

Measures to ensure ongoing improvements to the CHC model will include stakeholder engagement to provide participant input.

CHC will serve an estimated 450,000 individuals, including 130,000 older persons and adults with physical disabilities who are currently receiving LTSS in the community and in nursing facilities. CHC-MCOs will be accountable for most Medicaid-covered services, including preventive services, primary and acute care, LTSS (home and community-based services and nursing facilities), prescription drugs, and dental services. Participants who have Medicaid and Medicare coverage (dual eligible participants) will have the option to have their Medicaid and Medicare services coordinated by the same MCO.

1.2 Background

This initiative builds on the commonwealth's past success in implementing the country's most extensive network of Programs of All-inclusive Care for the Elderly (called LIFE, Living Independence for the Elderly, in Pennsylvania), which will continue to be an option for eligible persons, and five HCBS waiver programs, which will be replaced by CHC.[1] It also builds on the commonwealth's experience with HealthChoices, a statewide managed care delivery system for children and adults. Behavioral health services will continue to be provided through the Behavioral Health Services HealthChoices (BH-MCOs). CHC-MCOs and BH-MCOs will be required to coordinate services for individuals who participate in both programs.

The current LTSS system is expanding community options, but not rapidly enough to keep up with growing demand. Pennsylvania has made progress on reforming its LTSS system. The percentage of LTSS funding spent on HCBS increased from 37.3 percent in 2011 to 41.9 percent in 2013.[2] However, Pennsylvania still lagged significantly behind the national average of 51.3 percent spent on HCBS in 2013, ranking it 37th among states. Furthermore, the LTSS system operates separately from the Medicare and Medicaid physical health systems, leaving participants to navigate these complex programs on their own. Between 2002 and 2014, these challenges were documented by stakeholders in 10 significant planning groups, study commissions and work groups on LTSS. The following recommendations have consistently emerged over more than a decade of public discourse. [3]

[1] The six waiver programs that will be combined in CHC are: Aging, Attendant Care, AIDS, CommCare, Independence and OBRA. These waiver programs are currently managed by the DHS Office of Long-Term Living. In this paper, they will be referred to as the OLTL Waivers.

[2] Eiken et al. *Medicaid Expenditures for Long-Term Services and Supports (LTSS) in FY 2013: Home and Community-Based Services were a Majority of LTSS Spending.* June, 2015. http://www.medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/downloads/ltss-expenditures-fy2013.pdf Accessed 8/5/15.

[3] *Summary of Previous Long-Term Care Reports, Recommendations and Accomplishments/Activities; Prepared for the Pennsylvania Long-Term Care Commission*. June 30, 2014. http://www.dhs.state.pa.us/cs/groups/webcontent/documents/document/c_091262.pdf Accessed 8/5/15.

- Expand community LTSS options, and streamline and standardize the way people access them;
- Develop new models of care that integrate care coordination, service delivery, and financing;
- Innovate in the LTSS sector with creative housing and other supports, greater use of technology, and new strategies to recruit and retain direct care workers;
- Strengthen the focus on quality measurement, including both quality of life and quality of care, in order to achieve better outcomes; and
- Ensure long-term sustainability of the system as demand for LTSS grows.

In February 2015, Governor Wolf directed DHS and PDA to develop managed long-term services and supports to act on these longstanding recommendations. Following a national review of best practices, the commonwealth outlined the basis for CHC in a public discussion document.[4] In June and July, officials from DHS and PDA received verbal feedback at six public forums held across Pennsylvania, attended by over 800 stakeholders, and through written feedback. Comments were received from 316 organizations and individuals at the forums and via mail and e-mail. This concept paper takes into consideration the feedback on the discussion document.

> The commonwealth plans to coordinate health and long-term services and supports through CHC managed care organizations. Participants will have a choice between two to five CHC-MCOs in each region. The CHC rate model will include value-based incentives to increase the use of home and community-based services and meet other program goals. CHC will use standardized outcome measures of both program- and participant-level outcomes to assess overall program performance and improve CHC over time.

1.3 Program Vision and Goals

The vision for CHC is an integrated system of physical health and long-term Medicare and Medicaid services that supports older adults and adults with physical disabilities to live safe and healthy lives with as much independence as possible, in the most integrated settings possible.

[4] *Managed Long-Term Services and Supports (MLTSS) Discussion Document*. June, 2015. http://www.dhs.state.pa.us/cs/groups/webcontent/documents/document/c_183646.pdf Accessed 8/6/15.

The goals of CHC are as follows:

1. **Enhance opportunities for community-based living.** There will be improved person-centered service planning and, as more community-based living options become available, the ability to honor participant preferences to live and work in the community will expand. Performance incentives built into the program's quality oversight and payment policies will stimulate a wider and deeper array of HCBS options.

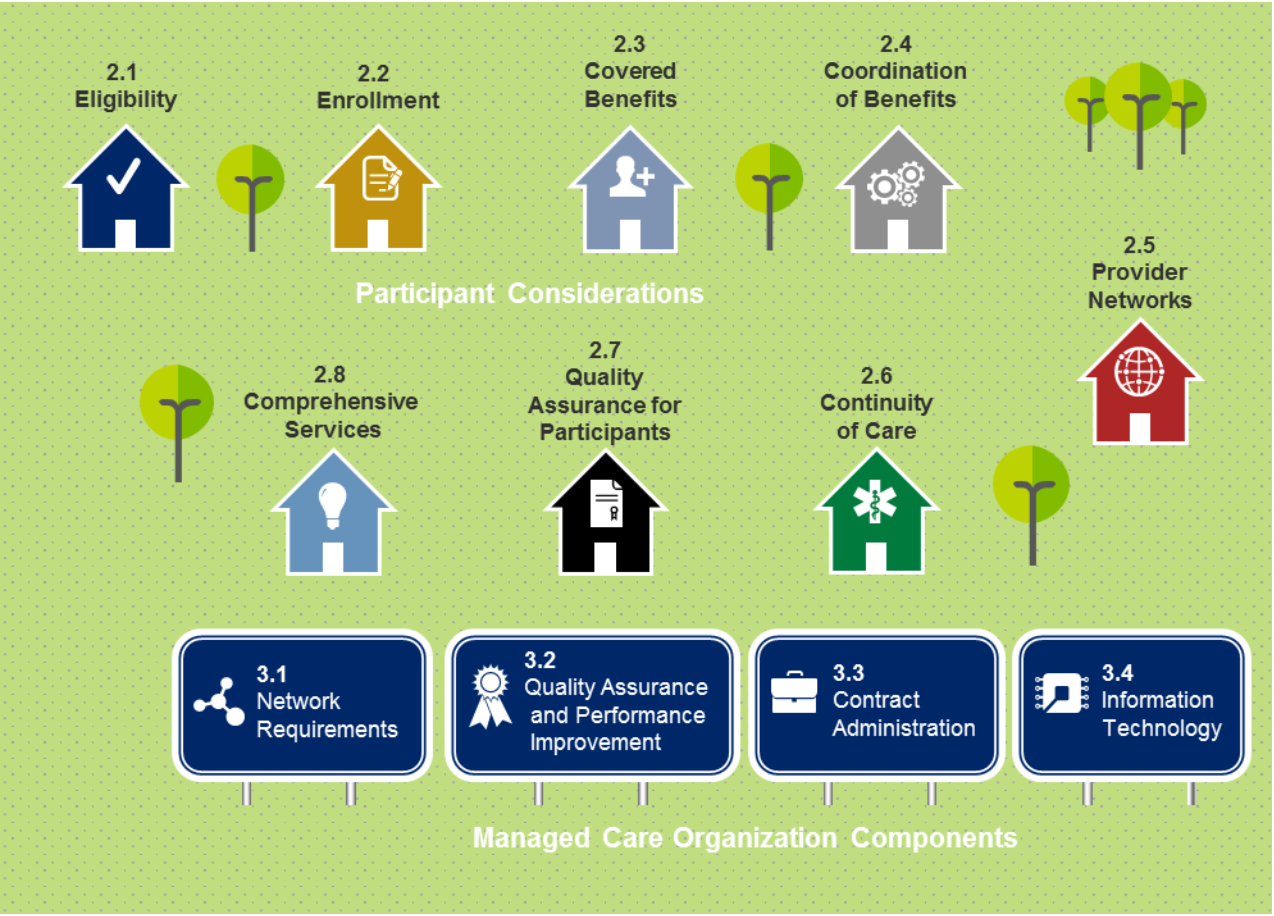
2. **Strengthen coordination of LTSS and other types of health care, including all Medicare and Medicaid services for dual eligible individuals.** Better coordination of Medicare and Medicaid health services and LTSS will make the system easier to use and will result in better quality of life, health, safety and well-being.

3. **Enhance quality and accountability**. CHC-MCOs will be accountable for outcomes for the target population, responsible for the overall health and long-term support for the whole person. Quality of life and quality of care will be measured and published, giving participants the information they need to make informed decisions.

4. **Advance program innovation.** Greater creativity and innovation afforded in the program will help to increase community housing options, enhance the LTSS direct care workforce, expand the use of technology, and expand employment among participants who have employment goals.

5. **Increase efficiency and effectiveness.** The program will increase the efficiency of health care and LTSS by reducing preventable admissions to hospitals, emergency departments, nursing facilities and other high-cost services, and by increasing the use of health promotion, primary care and HCBS.

2. Participant Considerations



2.1 Community HealthChoices Population

2.1 Eligibility

The estimated total statewide enrollment of dual eligibles, older persons, and adults 21 and older with physical disabilities for CHC is 450,000. The CHC population will include individuals with Medicaid-only coverage who receive or need LTSS, and individuals with full Medicare and Medicaid coverage (dual eligible), including those with and without LTSS needs.[5] The CHC population will not include Act 150

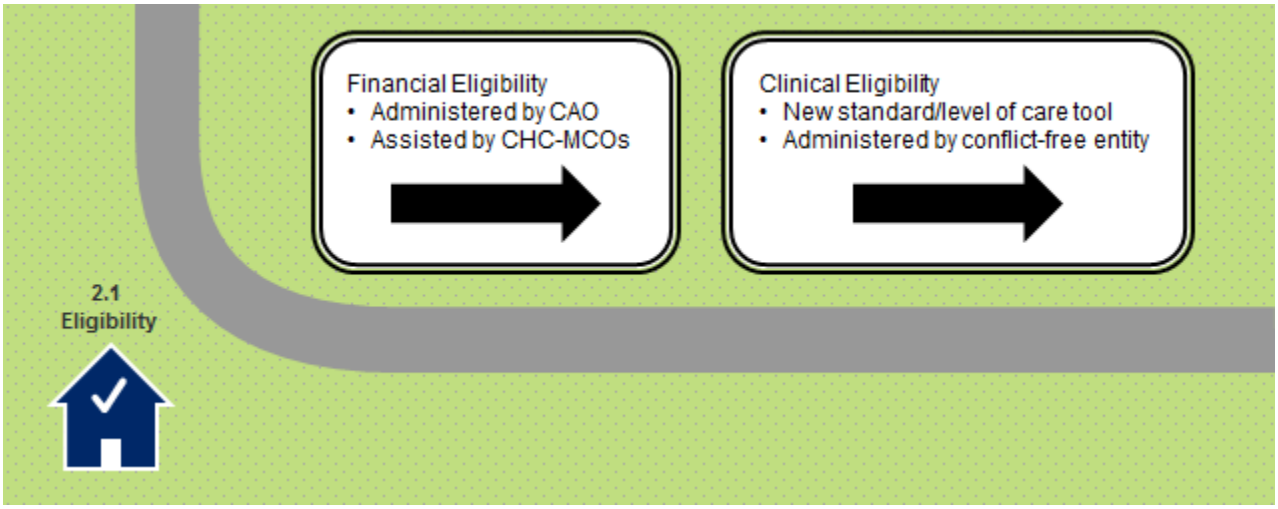
Highlights

- Eligibility
- Enrollment
- Benefits
- Coordination
- Provider Networks
- Continuity of Care
- Quality Assurance
- Comprehensive Services

[5] Full Medicare and Medicaid dual eligible participants are those with Medicare coverage and the full package of Pennsylvania Medicaid benefits.

program[6] participants, individuals receiving their services through the lottery-funded Options program, persons with intellectual/developmental disabilities (ID/DD) who receive services through the DHS Office of Developmental Programs, or residents of state-operated nursing facilities, including the State Veterans' Homes.

Eligibility of CHC Population



The CHC population will include the following:

- Adults age 21 or older who require Medicaid LTSS (whether in the community or in private or county nursing facilities) because they need the level of care provided by a nursing facility or an intermediate care facility for individuals with other related conditions (ICF/ORC);
- Current participants of DHS Office of Long Term Living (OLTL) waiver programs who are 18 to 21 years old; and
- Dual eligibles age 21 or older whether or not they need or receive LTSS.

Persons included in the CHC population will be required to enroll in CHC. However, persons who are eligible for the LIFE program will not be enrolled into CHC unless they specifically ask to be enrolled.

Financial Eligibility for CHC

The DHS Office of Income Maintenance will continue to administer the Medicaid financial eligibility process through the County Assistance Offices. Persons who are already financially eligible when CHC starts will not need to go through a different or

[6] The Act 150 Program is a state-funded program that provides personal assistance and other ancillary services to individuals with physical disabilities 18 to 60 years of age who do not have Medicaid coverage. The OPTIONS program is a Lottery-funded program that provides personal assistance and ancillary services to individuals over the age of 65 who do not have Medicaid coverage.

additional financial eligibility process prior to enrollment in CHC. New applicants will still need to be determined financially eligible for the program.

To facilitate continuous eligibility of CHC participants, the commonwealth will provide CHC-MCOs with eligibility renewal date information so CHC-MCOs can assist participants with the regular eligibility renewal process.

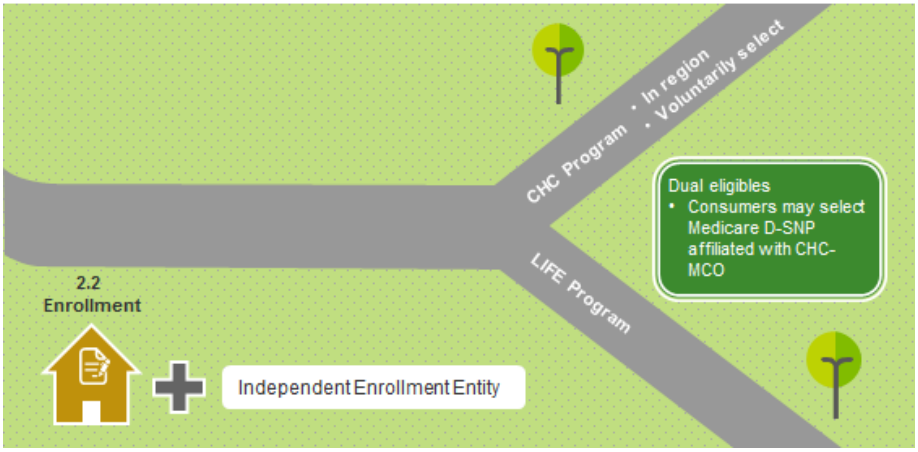
Level of Care Process

Persons who are clinically eligible for LTSS when CHC starts will not need to go through a new level of care assessment prior to enrollment in CHC. Persons who are seeking LTSS services for the first time will have a level of care assessment as part of the overall eligibility determination process.

The commonwealth will develop a standardized level of care tool to replace what is currently in use across the OLTL LTSS programs. The tool will be developed to be in compliance with all federal and state statutory and regulatory requirements. The commonwealth will contract with an entity to perform LTSS level of care determinations and redeterminations. The entity selected to perform this function will not be permitted to be a provider of service.

2.2 Enrollment

Persons who are included in the CHC population will be required to enroll in one of the CHC-MCOs operating in the region unless they choose to enroll in a LIFE program. The commonwealth will select an independent enrollment entity (IEE) through a competitive procurement process to advise CHC participants of their options and to help them with the enrollment process.



Initial Enrollment into CHC

Approximately three months prior to the implementation of CHC in a region, the IEE will notify all eligible participants of their upcoming transition into CHC and their enrollment options. The IEE and other resources (such as the PDA APPRISE program) will be available to provide information and counseling to eligible CHC participants regarding their enrollment choices. Eligible participants will receive several notifications regarding their need to choose one of the enrollment options.

The IEE will notify persons who become eligible for CHC after the initial implementation date (e.g. persons who are 21 and older and become dual eligibles for Medicare and Medicaid) of their enrollment options.

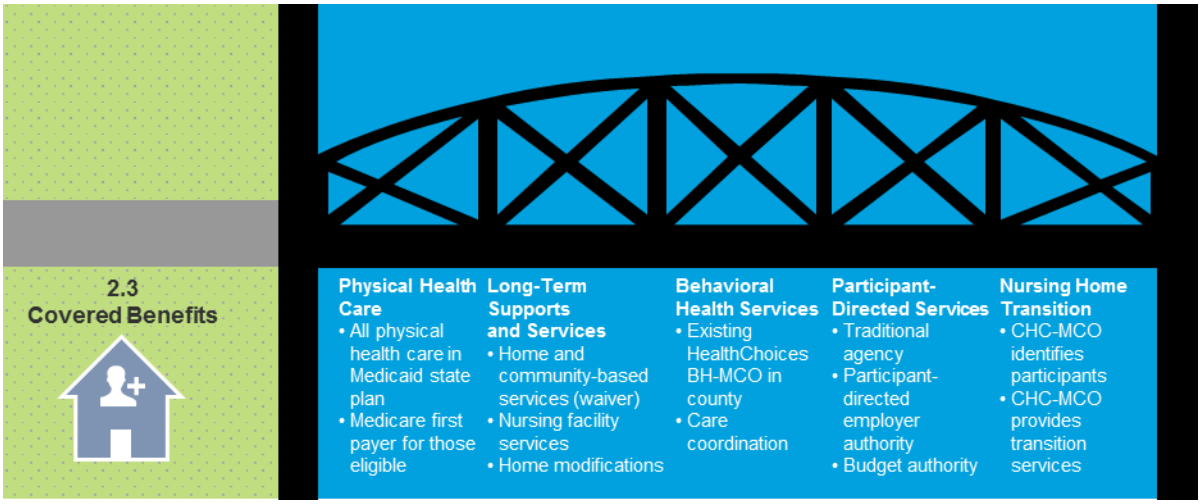
The IEE will assist individuals to voluntarily select one of the available CHC-MCOs in the region, or a LIFE program. If an eligible individual does not select either one of the CHC-MCOs or a LIFE program prior to an established deadline (e.g. 30 days prior to implementation), he or she will be automatically assigned to one of the CHC-MCO plans in the region and the individual will be notified by the IEE. The commonwealth will use an intelligent assignment approach that matches participants with the CHC-MCO that best meets their needs. Current enrollees in a Medicare Dual Eligible-SNP will be automatically enrolled in the CHC-MCO affiliated with that D-SNP, if available, although they will be allowed to switch to a different CHC-MCOs at any time. CHC will be the default enrollment option for program participants.

> The commonwealth is seeking input from stakeholders regarding factors it should consider for making "intelligent assignments" of participants who do not voluntarily select one of the CHC-MCOs or a LIFE program.

CHC-MCO Transfers

CHC participants may elect to switch from their current CHC-MCO to a different CHC-MCO in the region at any time. The effective date of the transfer will either be the 15th day of the month, or the 1st day of the month depending on when they request the change in CHC-MCO. Also, the IEE will annually notify all CHC participants of their option to switch from their current CHC-MCO to a different CHC-MCO, or to a LIFE program.

2.3 Covered Benefits



Physical Health Care Benefits

The CHC benefit package will include all physical health benefits specified in the Medicaid State Plan. For dual eligibles, Medicare will continue to be the first payer for benefits covered under both programs. For CHC participants who are not eligible for Medicare Part D pharmacy benefits, CHC will provide Medicaid pharmacy benefit coverage through a formulary consistent with the State Plan.

LTSS

The CHC benefit package will include nursing facility services and HCBS currently covered in the Aging, OBRA, Independence, COMMCare, AIDS, and Attendant Care waiver programs.

These benefits will be available to participants who meet the LTSS criteria.

CHC-MCOs may choose to provide LTSS to participants who are in need but do not meet the LTSS criteria or to offer additional LTSS benefits beyond those required in the CHC benefit package. The costs associated with these additional LTSS benefits will not be included in calculating the capitation payment made to the CHC-MCOs.

The commonwealth may add additional LTSS benefits not currently covered in the OLTL waivers.

See Appendix A for more detail on LTSS services that are proposed to be included in the CHC benefits package.

Behavioral Health Services

Participants will have access to behavioral health services through the existing HealthChoices BH-MCOs in each county. CHC-MCOs and BH-MCOs will be required to coordinate services for members they have in common.

Home Modifications

Home modifications to support HCBS will be a covered benefit under CHC. CHC-MCOs will contract with the entities that the commonwealth has chosen to act as brokers and to ensure that CHC participants have appropriate access to these services.

Participant-Directed Personal Assistance Services

CHC-MCOs will offer the choice of three different delivery models for personal assistance services to participants determined to need LTSS. First, participants will have the option to receive personal assistance services through a traditional agency model, in which the service coordinator arranges with a licensed agency enrolled with the CHC-MCO to provide the services in accordance with the person-centered services plan. Second, participants may elect to receive personal assistance services through a participant-directed employer authority model, in which the participant employs his or her own personal assistance provider, who can be a family member, a friend, a neighbor or any other qualified personal assistance worker.

CHC-MCOs will offer the choice of three different delivery models for personal assistance services to participants eligible to receive HCBS.

Third, participants may chose Services My Way, which is a budget authority model. In this model, the participant develops a spending plan to purchase needed goods and services based on their service plan budget. Participants in this model may elect to receive personal assistance through an agency and/or to employ their own personal assistance providers.

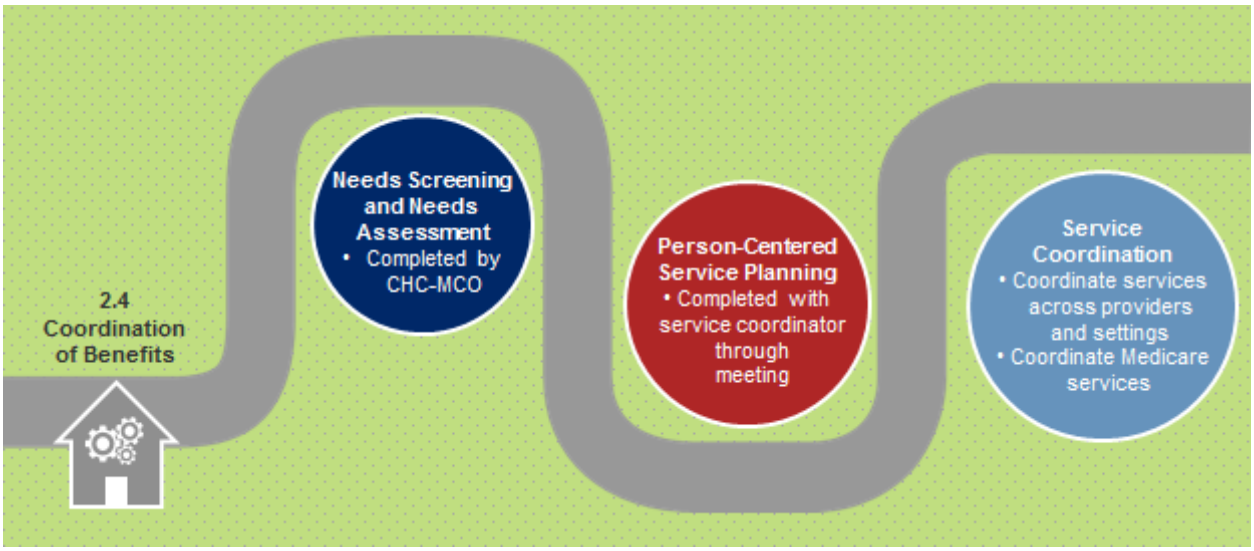
Personal assistance workers employed by participants under the self-directed model will become qualified and receive payment through a financial management services (FMS) vendor, which processes timesheets, makes payments, and manages all required tax withholdings. The commonwealth will have agreements with three statewide FMS entities, and CHC-MCOs will be required to contract with these entities to ensure personal assistance workers receive timely and appropriate payment for services rendered.

Nursing Home Transition Services

CHC-MCOs will offer Nursing Home Transition (NHT) services to participants residing in nursing facilities who express a desire to move back to their homes or other community-based settings. CHC-MCOs will contract with NHT providers to identify NHT-appropriate participants and coordinate their NHT services.

2.4 Coordination of Benefits

CHC will include participants with a broad range of needs, from relatively healthy dual eligible participants to people with multiple chronic conditions and LTSS needs.



Needs Screening and Needs Assessment

Each CHC-MCO will submit to the commonwealth for approval its plan and methods for regular needs screening of all participants. Methods may include, but are not limited to, telephone-administered needs screens and analysis of participant utilization. Participants found to be in need of supports and services through the screening process will be offered a comprehensive needs assessment based on a standardized tool approved by the commonwealth. The tool will be used to identify the participants' goals and preferences and addresses physical, social, psychosocial, environmental, LTSS, and other needs, as well as the availability and needs of participants through the support of unpaid caregivers.

Person-Centered Service Planning for LTSS and Others at Risk

All individuals in need of or receiving LTSS will have a service coordinator. The service coordinator will conduct a comprehensive needs assessment and assemble and monitor a person-centered service plan. Service coordinators will develop the service plan during a face-to-face meeting with the individuals and others who are invited to participate based on the needs and preferences of the participant. The service coordinator will update the plan annually or more frequently based on the needs of the participant.

> The plan must identify the needs, preferences, and goals of the participant and specify how the participant's physical health, LTSS, social, psychosocial, housing, and environmental needs will be met.

The person-centered service plan must be documented in a standardized, electronic form designated by the commonwealth. The plan must identify the needs, preferences, and goals of the participant and specify how the participant's physical health, LTSS, social, psychosocial, housing, and environmental needs will be met. If behavioral health needs are identified, the plan will include steps to coordinate appropriate behavioral health services with the BH-MCO. The plan must address preferences in where the participant lives, control and choice about schedule, and desired life activities. The CHC-MCO must also address needs of participants through support of their unpaid caregivers. The plan will serve as an authorization for the services outlined.

The service coordinator will monitor the person-centered service plan to ensure that authorized services are delivered, and will coordinate those services as needed. With consent of the participant, the service coordinator will share the person-centered service plans and related information with the participant's provider(s) and unpaid caregiver(s).

CHC-MCOs will be permitted to provide service coordination directly or through community partners, as long as expertise can be demonstrated. CHC-MCOs will be required to demonstrate that the service coordinators have expertise with the conditions of the target population, which include physical disability, brain injury, dementia, and a broad range of chronic conditions.

Service coordinators must be available and required to respond to all calls from participants in their caseloads during regular business hours. The CHC-MCO must have a system in place for redirecting and responding to participant calls made to service coordinators after business hours.

Service Coordination and Care Transitions

A major goal of CHC is to improve the coordination of services across providers and settings of care. In addition to providing service coordination for participants in need of LTSS, CHC-MCOs may provide service coordination to other participants identified through the risk screening process, or whose needs are otherwise identified by the participant, caregivers or the CHC-MCO. The need for service coordination may be indicated by the presence of one or more chronic conditions, use of multiple specialists, use of emergency departments or admissions to hospitals.

CHC-MCOs will be required to implement care transition protocols whenever participants are admitted to or discharged from hospitals, nursing facilities or residential settings.

CHC-MCOs will submit to the commonwealth for approval their plans for identifying the need for service coordination and care transition, and their plan for meeting those needs.

Coordination of Medicare for Dual Eligible Participants

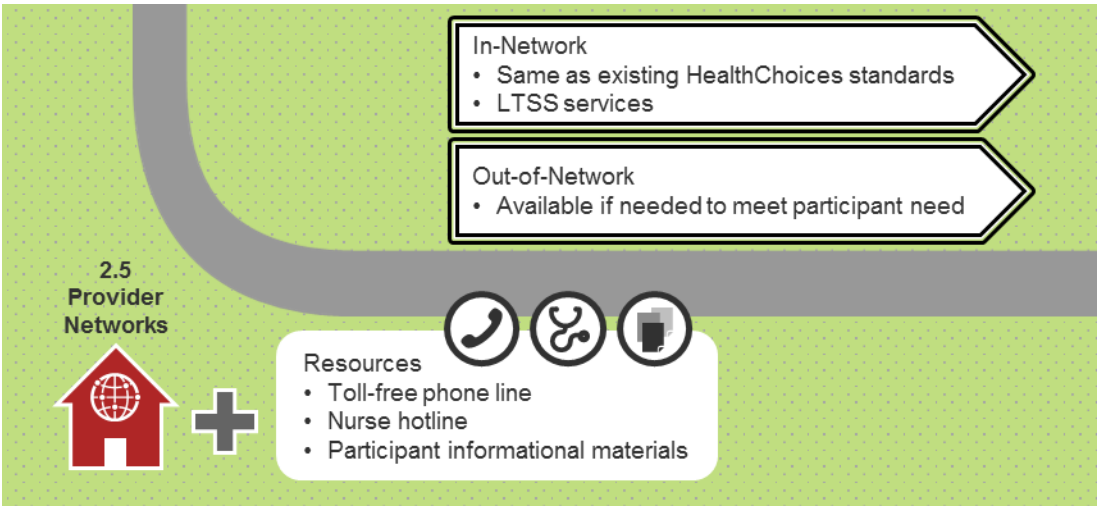
Over 90 percent of CHC participants are expected to have Medicare and Medicaid coverage. CHC-MCOs will be required to offer companion D-SNPs for dual eligible participants. Participants who choose the companion D-SNPs will have all their benefits seamlessly coordinated by one MCO, and may also receive supplemental Medicare benefits offered by the MCO.

Dual eligibles who do not wish to enroll in a companion D-SNP will not be required to do so. They will continue to have all the Medicare choices offered in their regions, including original Medicare. CHC-MCOs will be required to coordinate with the participant's Medicare health plan or the original Medicare Fee-for-Service program. CHC-MCOs will also be required to work with the Medicare Fee-for-Service providers to coordinate care for the participants.

A major policy objective of CHC is to improve the coordination of benefits across the Medicare and Medicaid programs for dual eligible participants. The commonwealth requests stakeholder input on how best to accomplish this goal.

2.5 Provider Networks

Provider network standards for CHC will mirror those of the existing HealthChoices program for hospitals, specialty clinics, trauma centers, facilities for high-risk deliveries and neonates, specialists, dentists, orthodontists, physicians, pharmacies, emergency transportation services, rehabilitation facilities, nursing facilities, home care providers, home health providers, certified hospice providers and durable medical equipment (DME) suppliers. For covered LTSS services, including nursing facilitiy services, the CHC-MCO must demonstrate a sufficient network to allow participants a choice of providers that are accessible to them and have expertise in LTSS.



If a CHC-MCO is unable to provide necessary covered services to meet the needs of a participant, the CHC-MCO must cover the services out-of-network.

CHC-MCOs must demonstrate that the providers in their network are knowledgeable and experienced in providing services to participants with special needs of all types, including the need for LTSS, and that provider offices and facilities comply with the accessibility standards of the Americans with Disabilities Act.

The provider network of each CHC-MCO must reflect the needs and service requirements of its culturally and linguistically diverse participant populations. Both CHC-MCOs and their providers must demonstrate cultural competency. Each CHC-MCO will be required to describe the cultural competency of its provider network in its network management plan, which is submitted annually to the commonwealth.

Additional network management requirements are included in Section 3.1.

Assistance for Participants within Provider Network

Each CHC-MCO must have a participant services department and toll-free telephone line to provide assistance, as needed, to participants. The staff of the participant services department should reflect the cultural diversity of the CHC-MCO's participants. If no one is available in the participant services department to speak with a participant in his or her native language, translation services will be made available. A CHC-MCO which operates multiple health plans in Pennsylvania may integrate its CHC participant services department with those of other plans, but the CHC-MCO must demonstrate sufficient capacity and cultural diversity to meet the needs of CHC participants.

Nurse Hotline

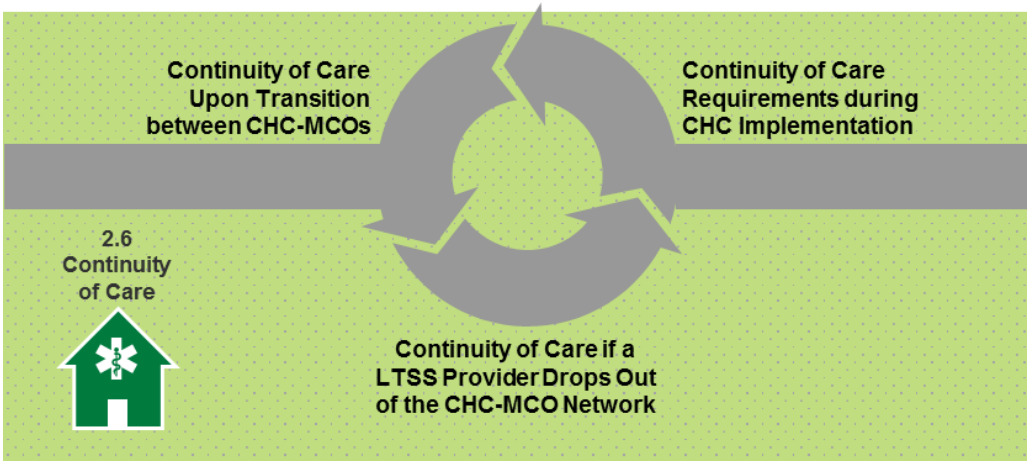
Each CHC-MCO must offer a nurse hotline that operates and accepts calls 24 hours per day, 7 days per week. The participant services department staff must be trained to recognize when CHC participants should be connected to the nurse hotline.

Participant Informational Materials

The CHC-MCO must ensure that all marketing materials and other participant materials are written at no higher than a fourth grade reading level and include, at a minimum, the information required by the commonwealth. All materials and participant information must be made available as needed in alternative languages and formats. Informational material must, at a minimum, be available upon request in Braille, large print, audio tape, compact disc (CD), and DVD, and must be provided in the format requested by the person with a visual impairment.

2.6 Continuity of Care

CHC will include provisions to help maintain continuity of care and avoid interruptions of service for participants when they are first enrolled in CHC, and when they choose to switch from one CHC-MCO to another.



Continuity of Care Requirements during CHC Implementation

Continuity of care for CHC also includes continuity of LTSS providers. Each CHC-MCO must initially include in its networks all willing and qualified LTSS service providers in the CHC-MCO service regions that are currently enrolled in the Medicaid program to provide HCBS services in the OLTL waiver programs or nursing facility services. A willing and qualified provider is one that agrees to meet the CHC-MCO quality standards and accept the CHC-MCO payment rate. This requirement will apply during the first six months of each phase of implementation.

Waiver participants enrolling in CHC as part of the transition into managed care will continue to have access to all services and providers authorized in their service plan that were in effect the day before CHC enrollment. This continuity of care authorization will last for 180 days or until a new person-centered service plan is developed, whichever comes later. The CHC-MCO may increase the level of LTSS services during the continuity of care period in response to increased participant needs, but may not reduce services. Any new person-centered service plan developed by the CHC-MCO that proposes to reduce any one service by more than 25 percent must be approved by the commonwealth prior to implementation.

Participants residing in a nursing facility on the date of initial program implementation may continue to reside at that nursing facility indefinitely, as long as they continue to meet LTSS criteria.

Similar to the existing HealthChoices continuity of care rules, participants may continue to use physical health providers with which they had existing relationships for the first 60 days of their enrollment in CHC.

Continuity of Care Upon Transition between CHC-MCOs

If a participant chooses to transfer from one CHC-MCO to another CHC-MCO, the participant will continue to have access to all existing LTSS providers and must continue to receive any LTSS services in his or her service plan for 60 days from the date of the transfer or until a new person-centered service plan is developed by the new CHC-MCO, whichever is later. CHC-MCOs are required to transfer existing person-centered service plans when a participant moves from one plan to another within five business days of the participant's enrollment in the new plan.

Participants may continue to use physical health providers with whom they had existing relationships for the first 60 days after the transfer from one CHC-MCO to another.

Continuity of Care if an LTSS Provider Drops Out of the CHC-MCO Network

If an LTSS provider chooses to drop out of a CHC-MCO's network, any participant receiving services from that provider will continue to receive services from that provider until an alternative LTSS provider in the network can be identified. CHC-MCO agreements with LTSS providers must include provisions that guarantee the continuation of services and payment until a replacement provider is found, should a provider elect to drop out of the network.

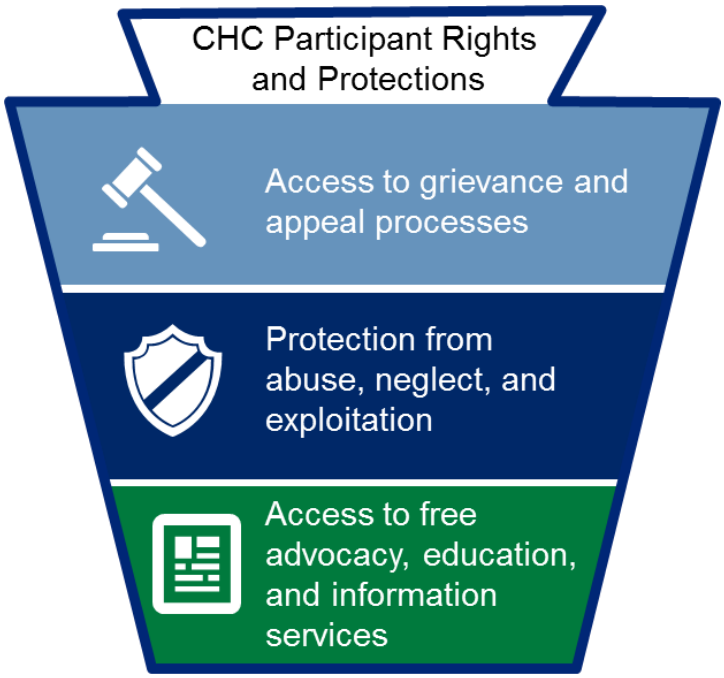
2.7 Quality Assurance for Participants

Quality services are a central component of CHC. Participants will benefit from quality management programs through which the CHC-MCOs will be required to demonstrate their ability to provide and improve accessibility, availability, and quality of care in their networks.

The components of the quality management program will include at a minimum:

- MCO quality management leadership, staffing, quality improvement committee and other infrastructure;
- Member feedback mechanisms, including participant surveys and focus groups, and the presence of a participant as a full member of the CHC-MCO's internal quality improvement committee;
- Provider monitoring;
- Mechanisms for tracking receipt of services;
- Critical incident reporting;
- Risk assessment and mitigation;

- Performance measure reporting;
- Performance improvement projects (PIPs);
- MCO involvement in External Quality Review Organization (EQRO) activities;
- Care coordination requirements related to maximizing the health and welfare of members;
- Quality-related financial incentives; and
- Quality reporting to the commonwealth.

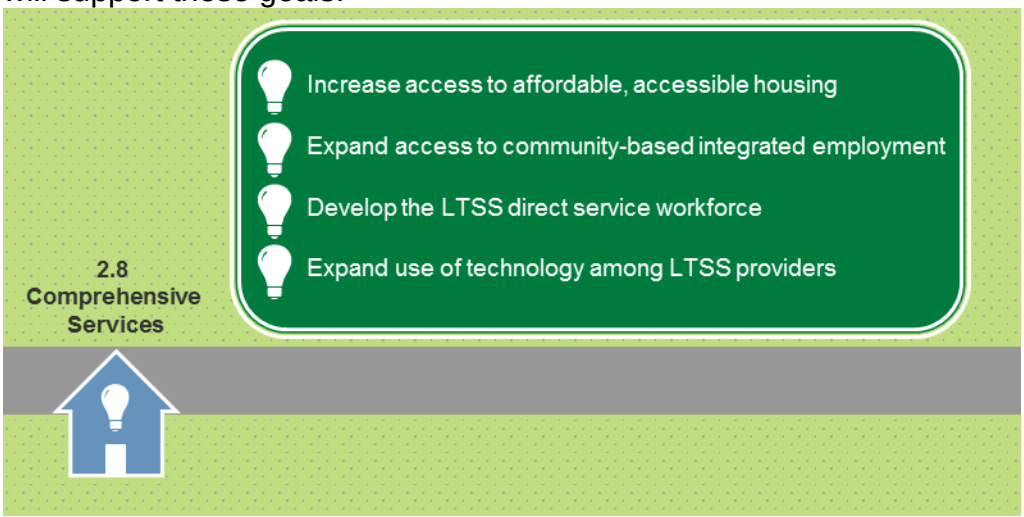


Additional information about CHC-MCOs' quality requirements are included in Section 3.2.

Additional information about participant rights and protections are included in Appendix B.

2.8 Comprehensive Services

CHC will be designed to encourage CHC-MCOs to offer a comprehensive approach to LTSS. The commonwealth is requesting input to initiatives that will support these goals.



Specifically, the commonwealth seeks stakeholder input methods and opportunities to:

- Increase access to affordable and accessible housing to support community living;
- Expand access to community-based integrated employment;
- Develop an expanded and skilled LTSS workforce; and
- Expand the use of technology supporting community-based LTSS services and the integration of services across the entire continuum.

3. Managed Care Organization Components

3.1 Network Requirements

Every CHC-MCO must develop and maintain a network management plan. The network management plan must be submitted to the commonwealth and reviewed during readiness review activities. Annual updates to the network management plan must be submitted to the commonwealth.

Highlights

- Network Requirements
- Quality Assurance
- Contract Administration
- Information Technology

The network management plan must address the following areas:

- How the CHC-MCO will communicate and negotiate with network providers regarding contractual, continuity of care, and program changes and requirements before updating the provider manual annually;
- How the CHC-MCO will monitor network provider compliance with policies and rules of CHC, including compliance with all policies and procedures related to the grievance and appeal processes while ensuring the participant's services are not interrupted during the grievance and appeal processes;
- How the CHC-MCO will evaluate the quality of services delivered by network providers;
- How the CHC-MCO will provide or arrange for medically necessary covered services when one or more network providers terminate their participation in the network;
- How the CHC-MCO will monitor the adequacy, accessibility, and availability of its provider network to meet the needs of its participants, including the provision of care to participants with limited English proficiency;
- How the CHC-MCO will recruit, select, credential, re-credential, and contract with providers in a manner that incorporates quality management, utilization, office audits, and provider profiling;
- How the CHC-MCO will provide training for its providers and maintain records of such training;
- How the CHC-MCO will track and trend provider inquiries, complaints and requests for information and take systemic action as necessary and appropriate; and

- How the CHC-MCO will ensure that providers are returning calls within three business days of receipt.

Network Changes/Provider Terminations

All material changes in the CHC-MCO's provider network must be approved in advance by the commonwealth. A material change to the provider network is defined as one which affects, or can reasonably be foreseen to affect, the CHC-MCO's ability to meet the performance and network standards as described in the CHC agreement. It also includes any change that would cause more than 5 percent of participants in the region to change the location where services are received or rendered. The CHC-MCO must submit to the commonwealth a request for approval of a material change in its provider network, including a draft notice to affected participants before the notice is sent. The request must include a description of any short-term gaps identified as a result of the change and the alternatives that will be used to fill them.

All material changes in the CHC-MCO's provider network must be approved in advance by the commonwealth.

The CHC-MCO must have procedures to address changes in its network that impact participant access to services.

Provider Services

Every provider in the CHC-MCO's network is assigned a provider representative, who will be the first point of contact for that provider to address any issues the provider may have in meeting the needs of participants.

The CHC-MCO must operate provider services functions at a minimum during regular business hours (9:00 a.m. to 5:00 p.m., Monday through Friday). Provider services functions include, but are not limited to, the following:

- Assisting providers with questions concerning the eligibility or enrollment status of CHC participants;
- Assisting providers with the CHC-MCO's prior authorization and referral procedures;
- Assisting providers with claims payment procedures and handling provider disputes regarding outstanding claims;
- Facilitating transfer of participant medical records among medical providers, as necessary;

- Providing all providers with a monthly list of participants who are under their care, including the identification of new and discontinued participants; and
- Coordinating the administration of out-of-network services.

Provider Manuals

The CHC-MCO must keep its network providers up-to-date with the latest policies and procedures that govern CHC. The key to maintaining this level of communication is the publication and maintenance of a CHC provider manual. The CHC-MCO must work with the commonwealth on the development of the provider manual. Copies of the provider manual must be distributed in a manner that makes them easily accessible to all network providers. The provider manual must be updated annually. The commonwealth may grant an exception to this annual requirement upon written request from the CHC-MCO provided there are no major changes to the manual.

Provider Education and Training

The CHC-MCO must demonstrate that its provider network is knowledgeable and experienced in treating CHC participants with diverse needs. Within its network management plan, the CHC-MCO must submit an annual provider education and training plan to the commonwealth which includes its process for measuring training outcomes, including the tracking of training schedules and provider attendance.

At a minimum, provider training must address, as appropriate, the following areas:

- Identification of and appropriate referral for mental health, drug and alcohol, and substance use services;
- Sensitivity training on diverse and special needs populations such as persons who are deaf or hard of hearing, including how to obtain sign language interpreters and how to work effectively with sign language interpreters;
- Cultural competency, including the right of participants with limited English proficiency to engage in effective communication in their language, how to obtain interpreters and how to work effectively with interpreters;
- Provision of services to special needs populations, including the right to treatment for individuals with disabilities, and the requirements of the Americans with Disabilities Act;
- Administrative processes that include, but are not limited to, coordination of benefits, recipient restriction program, encounter data reporting and dual eligible issues;
- Issues identified by provider relations staff in response to calls or complaints by providers;

- Issues identified through the quality management process;
- Prevention and detection of fraud, waste, and abuse; and
- Participant-directed services.

A CHC-MCO may collaborate with other CHC-MCOs to develop and implement provider training and education. Any collaborative activities must be specified in the CHC-MCO's provider training and education plan.

3.2 Quality Assurance and Performance Improvement

The CHC-MCO must provide for the delivery of quality physical health care and LTSS with the primary goal of improving the health and functional status of participants as well as preventing deterioration or decline. The CHC-MCO must work in collaboration with providers to actively improve the quality of care and services provided to participants, consistent with quality improvement goals rquired by the commonwealth. The CHC-MCO must provide mechanisms for participants and providers to offer input into quality improvement activities.

DHS will administer the quality management (QM) and utilization management (UM) components of this program. The CHC-MCO must comply with the QM and UM program standards and requirements established by DHS relating to external quality review, QM/UM deliverables, CHC-MCO pay for performance program, provider pay for performance program and community-based care management program. The CHC-MCO must comply with all QM and UM program reporting requirements and must submit data in formats to be determined by the commonwealth.

In collaboration with the CHC-MCO, the commonwealth may determine and prioritize QM and UM activities and initiatives based on areas of importance to DHS and CMS.

Quality Management and Performance Improvement Structure

The CHC-MCO will maintain QM and performance improvement processes and structures. The CHC-MCO will execute processes to assess, plan, implement, evaluate, and, as mandated, report QM and performance improvement activities.

The CHC-MCO must have a QM department that is separate from any other units or departments within the CHC-MCO organizational structure, including medical management, service coordination, or UM. The CHC-MCO must designate a senior executive responsible for the QM program, and the medical director must have substantial involvement in QM and performance improvement program activities. At a

minimum, the CHC-MCO must ensure that the QM structure is organization-wide, with clear lines of accountability within the organization, and includes a set of functions, roles, and responsibilities for the oversight of QM and performance improvement activities that are clearly defined and assigned to appropriate individuals.

The CHC-MCO must establish and maintain distinct policies and procedures regarding LTSS and must specify the responsibilities and scope of the authority of service coordinators in authorizing LTSS and in submitting authorizations to providers. This includes having in place an authorization process for covered LTSS and for cost-effective alternative services that is separate from, but integrated with, the CHC-MCO's prior authorization process for covered physical health services.

> The CHC-MCO will execute processes to assess, plan, implement, evaluate, and as mandated, report QM and performance improvement activities.

The QM structure must also ensure that for transitioning participants who are receiving LTSS as of the date of implementation, the CHC-MCO will be responsible for continuing to provide the LTSS previously authorized for the participant in accordance with continuity of care provisions.

The CHC-MCO QM and UM programs must be designed to assure and improve the accessibility, availability, and quality of care being provided to participants. The CHC QM and UM programs must, at a minimum:

- Contain the written program description, work plan, evaluation, and policies and procedures that meet requirements specified by the commonwealth;
- Allow for the development and implementation of an annual work plan of activities that focuses on areas of importance as identified by the CHC-MCO in collaboration with DHS;
- Be based on statistically valid clinical and financial analysis of encounter data, member demographic information, Healthcare Effectiveness Data and Information Set (HEDIS), Consumer Assessment of Healthcare Providers and Systems (CAHPS), Pennsylvania performance measures, and other data that allow for the identification of prevalent medical, behavioral, and LTSS needs, barriers to care, and racial or ethnic disparities to be targeted for quality improvement and other initiatives;
- Allow for the continuous evaluation of CHC-MCO activities and adjustments to the program based on the evaluations;

- Demonstrate sustained improvement of clinical performance over time;
- Allow for the timely, complete, and accurate reporting of encounter data and other data required to demonstrate clinical and service performance; and
- Include processes for the investigation and resolution of individual performance or quality of care issues, whether identified by the CHC-MCO or the commonwealth, which allow for the tracking and trending of issues on an aggregate basis pertaining to problematic patterns of care, and allow for submission of improvement plans, as determined by and within time frames established by the commonwealth.

For standards related to CHC-MCOs' QM and UM programs, see Appendix C.

Provider Profiling

The CHC-MCO will conduct Primary Care Physician (PCP) and other provider profiling activities at least annually. The CHC-MCO must describe the methodology it will use to identify which and how many providers to profile and to identify measures to use for profiling the providers. The CHC-MCO must:

- Use the results of its provider profiling activities to identify areas of improvement for PCPs and other providers;
- Establish provider-specific quality improvement goals for priority areas in which a provider or providers do not meet established CHC-MCO standards or performance improvement goals;
- Develop and implement incentives, which may include financial and non-financial incentives, to motivate providers to improve performance on profiled measures; and
- At least annually, measure and report to DHS on the provider network and individual providers' progress, or lack of progress, towards the improvement goals.

Performance Improvement Projects (PIPs)

The CHC-MCO will perform at least two clinical and three non-clinical PIPs as determined by the commonwealth in conjunction with the CHC-MCO. Clinical PIPs include projects such as prevention and care of acute and chronic conditions, high-volume services, high-risk services, LTSS, and continuity and coordination of care. Non-clinical PIPs include projects such as availability, accessibility, and cultural competency of services, interpersonal aspects of care, and appeals, grievances, and complaints.

The CHC-MCO must follow CMS protocols for PIPs and demonstrate its steps in meeting those protocols.

The CHC-MCO must identify benchmarks and set achievable performance goals for each of its PIPs. The CHC-MCO must identify and implement intervention and improvement strategies for achieving the performance goals set for each PIP and promoting sustained improvements.

The CHC-MCO must report on PIPs. The CHC-MCO will submit one PIP summary report that includes region-specific data and information to DHS, including improvement strategies as required by CMS.

After three years, the CHC-MCO must, using evaluation criteria established by the commonwealth, determine if one or all of the PIPs should be continued.

NCQA Accreditation

CHC-MCOs must be accredited by the National Committee for Quality Assurance (NCQA). CHC-MCOs will also have to meet expanded accreditation standards that specifically address LTSS, which are currently under development.

Pay for Performance Program (P4P)

The commonwealth will include a P4P program in CHC to provide financial incentives to CHC-MCOs that meet quality goals. One of the P4P strategies under consideration is the CHC-MCO's performance on diverting persons from institutional placements, both hospitals and nursing facilities, through person-centered service plans that identify areas of need. The P4P program for CHC-MCOs will include identification of the target population, the interventions by the service coordinator for persons in need, documentation of the interventions, and incremental results reporting.

The CHC-MCOs will be required to develop P4P programs for providers. All provider P4P programs must target improvements in the quality of or access to services for participants and may not limit the appropriate use of services by participants. The CHC-MCO must develop and submit a proposal to the commonwealth for review prior to implementation.

QM and UM Program Reporting Requirements

The CHC-MCO must comply with all QM and UM program reporting requirements and time frames. DHS will, on a periodic basis, review the required reports and make changes to the information, data, and formats requested based on the changing needs of CHC. The CHC-MCO must comply with all requested changes to the report information and formats.

The CHC-MCO must audit a sample of the person-centered service plans as part of its QM and UM programs. The CHC-MCO must use a protocol approved by DHS to select the sample. Audit results must be submitted to DHS.

The CHC-MCO must submit HEDIS® data to the commonwealth annually.

The CHC-MCO must submit CAHPS data to the commonwealth. In addition, the commonwealth is monitoring the availability of nationally-validated experience of care surveys for HCBS populations and plans to require the use of such surveys when they become available.

External Quality Review

The CHC-MCO will be required to cooperate fully with any external evaluations and assessments of its performance conducted by the commonwealth's contracted External Quality Review Organization (EQRO) or other designee. Independent assessments will occur at least annually and will include, but not be limited to, any independent evaluation required or allowed by federal or state statute or regulation.

Delegated UM Functions

Compensation and payments to individuals or entities that conduct UM activities may not be structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any participant.

Confidentiality

The CHC-MCO must have written policies and procedures for maintaining the confidentiality of medical records, participant information, and provider information that comply with the provisions set forth in Section 2131 of the Insurance Company Law of 1921, as amended, 40 P.S. 991.2131; 55 Pa. Code Chapter 105; and 45 CFR Parts 160 and 164 (Standards for Privacy of Individually Identifiable Health Information).

The CHC-MCO must ensure that provider offices and sites have implemented mechanisms that guard against unauthorized or inadvertent disclosure of confidential information to persons outside the CHC-MCO.

The CHC-MCO must obtain advance written approval from DHS before releasing data to any third party unless the release is for the purpose of individual care and coordination among providers, the release is authorized by the participant, or the release is required by court order, subpoena or law.

DHS Oversight

The CHC-MCO and its network providers and other subcontractor(s) will be required to make available to DHS and other oversight agencies upon request, data, clinical, and other records and reports for review of quality of care, access and utilization issues, including but not limited to activities related to external quality review, HEDIS, encounter data validation, program evaluation, and other related activities.

The CHC-MCO must submit a corrective action plan, in accordance with the time frames established by DHS, to resolve any performance or quality of care deficiencies identified through ongoing monitoring activities or any independent assessments or evaluations requested by DHS.

The CHC-MCO must obtain advance written approval from DHS before participating in or providing letters of support for QM or UM data studies or any data-related external research projects related to CHC.

3.3 Contract Administration

The CHC-MCOs must have in place the organizational, operational, managerial, and administrative systems capable of fulfilling all CHC requirements. This includes, at a minimum, employee screening, subcontractor oversight, employing sufficient staff, ability to work with the commonwealth on urgent issues, and identification of key staff qualified to serve the population.

3.4 Information Technology

The CHC-MCOs will be required to accept and transmit standard transaction data sets with the commonwealth which will include, but not be limited to:

- Eligibility transactions (834);
- Encounter transactions (837);
- Capitation payment transactions (820); and
- Quality assurance and incident management transactions.

See Appendix D for an overview of information technology requirements.

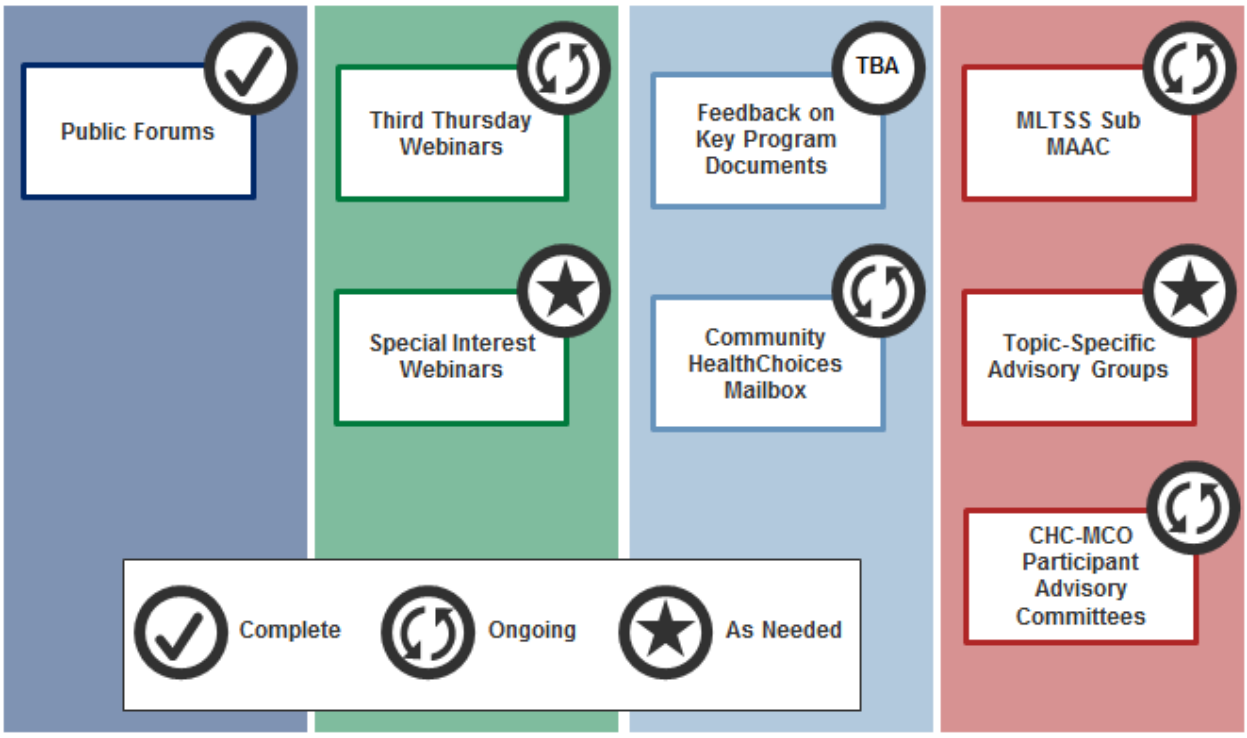
4. Stakeholder Engagement Process

The CHC initiative has had and will continue to have a robust and extensive stakeholder engagement process throughout the development and implementation of the program. Stakeholder input is key to the overall success of the program, and the commonwealth is committed to eliciting stakeholder input through a variety of channels, as follows.

Highlights

- Meetings
- Webinars
- Open Feedback
- Advisory Groups

Pennsylvania MLTSS Stakeholder Engagement Process



4.1 Public Forums

As noted above, stakeholder engagement began formally in June 2015 with the call for comments on the commonwealth's discussion document. The input received on the discussion document and related public meetings was analyzed and considered in the preparation of this document.

4.2 CHC Advisory Committee

In August 2015, after seeking nominations from interested parties, the commonwealth established the Managed Long-Term Services and Supports System Subcommittee (MLTSS SubMAAC) as a subcommittee of the Medical Assistance Advisory Committee (MAAC) to advise the commonwealth on the design, implementation, oversight, and improvement of CHC. Fifty percent of the Committee's members are LTSS participants or caregivers. The MLTSS SubMAAC's initial role is to provide advice on the design of the CHC program. The MLTSS SubMAAC will continue to meet throughout development and implementation of CHC and will provide ongoing advice on program improvement in the post-implementation period. All meetings of the MLTSS SubMAAC are open to the public and governed by MAAC bylaws. CHC-MCOs will be required to provide information to the MLTSS SubMAAC as needed.

4.3 Third Thursday Webinars

The commonwealth is holding public webinars, currently on the third Thursday of every month, to provide updates on the progress of the CHC program development and to take questions from the public. The webinars are a direct response to feedback provided by participants, who requested virtual meetings to make attendance and participation more accessible. Information about past and upcoming webinars can be found on the DHS-CHC website at:

http://www.dhs.state.pa.us/foradults/managedlongtermsupports/index.htm

4.4 Stakeholder Input on Key Program Documents

The commonwealth will continue to seek feedback from stakeholders on key program documents.

4.5 CHC Mailbox

The commonwealth maintains a mailbox that stakeholders can use at any time to ask questions or make comments about CHC. The mailbox address is: RA-MLTSS@pa.gov.

4.6 Webinar Consultations on Topics of Special Interest

In addition to the regularly scheduled webinars, the commonwealth will hold webinars on topics of special interest regarding CHC design features for which stakeholder input is needed. For example, the commonwealth may hold a webinar that addresses what types of counseling and information should be made available to prospective CHC participants at the point at which they are being asked to select a CHC-MCO. The

schedule for webinars on topics of special interest will be posted on the DHS Community HealthChoices website.

4.7 Topic-Specific Advisory Groups

The commonwealth will also form topic-specific advisory groups on issues that are of strong concern to specific groups of stakeholders and are technical in nature. For example, the commonwealth plans to form groups of CHC-MCOs and LTSS providers to formulate a common credentialing application process and common billing process across all LTSS providers for consistency and simplicity.

4.8 CHC-MCO Participant Advisory Committees

Each CHC-MCO will be required to establish and maintain a Participant Advisory Committee that reflects the diversity of participants enrolled in the CHC-MCO. The commonwealth will require CHC-MCOs to report on the membership and activities of their Participant Advisory Committees. The CHC-MCOs will also be required to report on how they have responded to concerns raised by their Participant Advisory Committees.

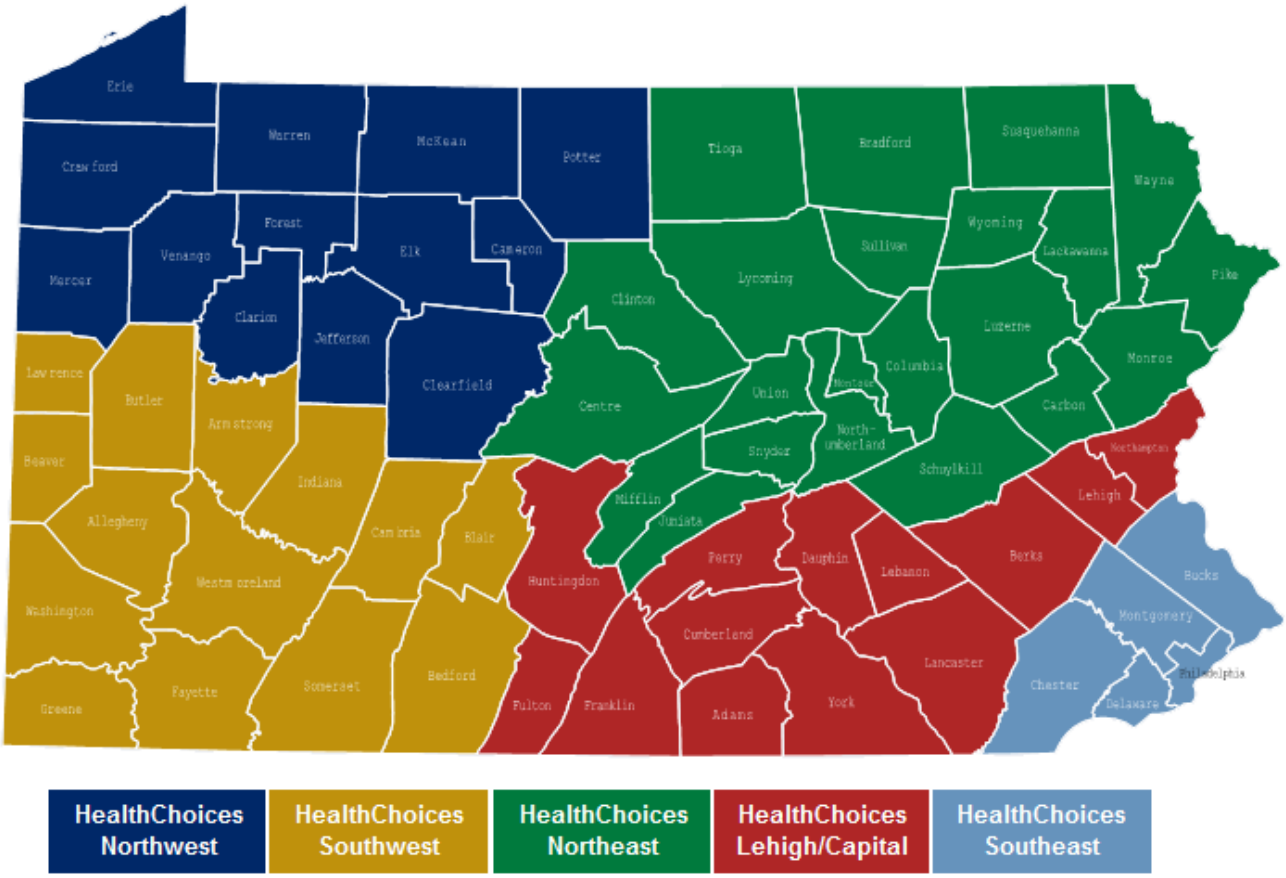
5. Regions and Timeline

Highlights

- Regional structure mirrors HealthChoices
- Phased timeline

Pennsylvania will issue a RFP for CHC-MCOs in November 2015 and will make tentative awards in March 2016, contingent upon successful readiness reviews and negotiations. MCOs may elect to submit proposals on any number of the five HealthChoices regions (see figure below). The commonwealth intends to award a minimum of two and a maximum of five CHC-MCO agreements in each region. The number of agreements awarded in each region will depend on the number of quality proposals submitted and the number of eligible persons in the region.

HealthChoices Regions



CHC will be implemented in three phases through one RFP. The program will go live in the Southwest region in January 2017, the Southeast region in January 2018, and the Northwest, Lehigh-Capital and Northeast regions in January 2019.

MLTSS Timeline

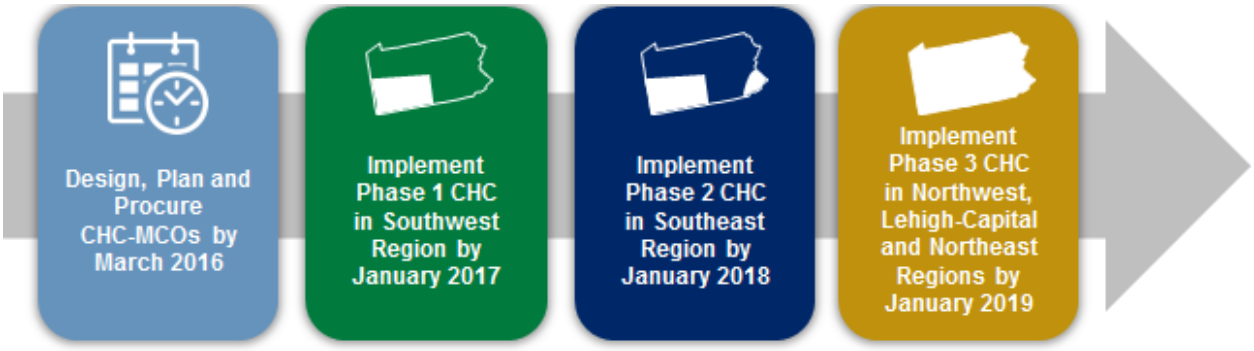


Table 1 presents the preliminary schedule for the procurement and implementation of CHC.

Table 1. Preliminary Procurement and Implementation Schedule

Milestone Description	Date
Deadline for submission of comments on this document	October 16, 2015 (5:00 pm)
Release of RFP for CHC-MCOs	November 16, 2015
Technical questions on RFP due to the commonwealth	November 25, 2015 (5:00 pm)
Pre-proposal conference	December 2, 2015
Answers to technical questions provided by the commonwealth	December 11, 2015
Deadline for submission of proposals	January 15, 2016 (5:00 pm)
Qualified Offerors respond to written questions and make oral presentations as requested by commonwealth	January-February 2016
CHC-MCOs notified of selection (all regions)	March 2016
Agreement negotiations for Phase 1 CHC-MCOs	March-June 2016
Readiness reviews for Phase 1 CHC-MCOs	March-December 2016
Phase 1 CHC participants receive enrollment notices	October 2016
Implementation of Phase 1 (Southwest region)	January 2017
Implementation of Phase 2 (Southeast region)	January 2018
Implementation of Phase 3 (Northwest, Lehigh-Capital and Northeast regions)	January 2019

Appendix A. Long-Term Services and Supports

The CHC benefit package will include the following LTSS services for CHC participants who meet LTSS criteria:

- Adult Daily Living
- Adult Daily Living Enhanced
- Assistive Technology
- Behavior Therapy
- Cognitive Rehabilitation Therapy
- Community Integration
- Counseling
- Home Adaptations
- Home Delivered Meals
- Home Health Aide
- Home Health – RN
- Home Health – LPN
- Home Health – Physical Therapy
- Home Health – Occupational Therapy
- Home Health – Speech and Language Therapy
- Non-Medical Transportation
- Nursing Facility Services
- Nutritional Counseling
- Personal Assistance Services
- Personal Emergency Response System
- Prevocational Services
- Residential Habilitation
- Respite
- Service Coordination
- Specialized Medical Equipment and Supplies
- Structured Day Habilitation
- Supported Employment

- TeleCare
- Vehicle Modifications

CHC-MCOs may choose to provide LTSS to participants who are at risk but do not meet the LTSS criteria or to offer additional LTSS benefits beyond those required in the CHC benefit package.

The commonwealth is interested in receiving stakeholder input on additional HCBS services that might be covered under CHC, with an emphasis on services that would be most effective in helping to delay or avoid nursing home placements for CHC participants

Appendix B. Participant Rights and Protections

Participant Rights and Protections

The commonwealth's agreements with CHC-MCOs will specify participant rights and responsibilities, and will require CHC-MCOs to notify participants of their rights and responsibilities in writing.

Grievance and Appeal Processes

All participants will have access to grievance and appeal processes that provide the same protections afforded in HealthChoices. The commonwealth is exploring ways to streamline Medicare and Medicaid grievance and appeal processes for dual eligibles. The participant handbook must provide clear information to participants regarding the preparation and filing of grievances and appeals.

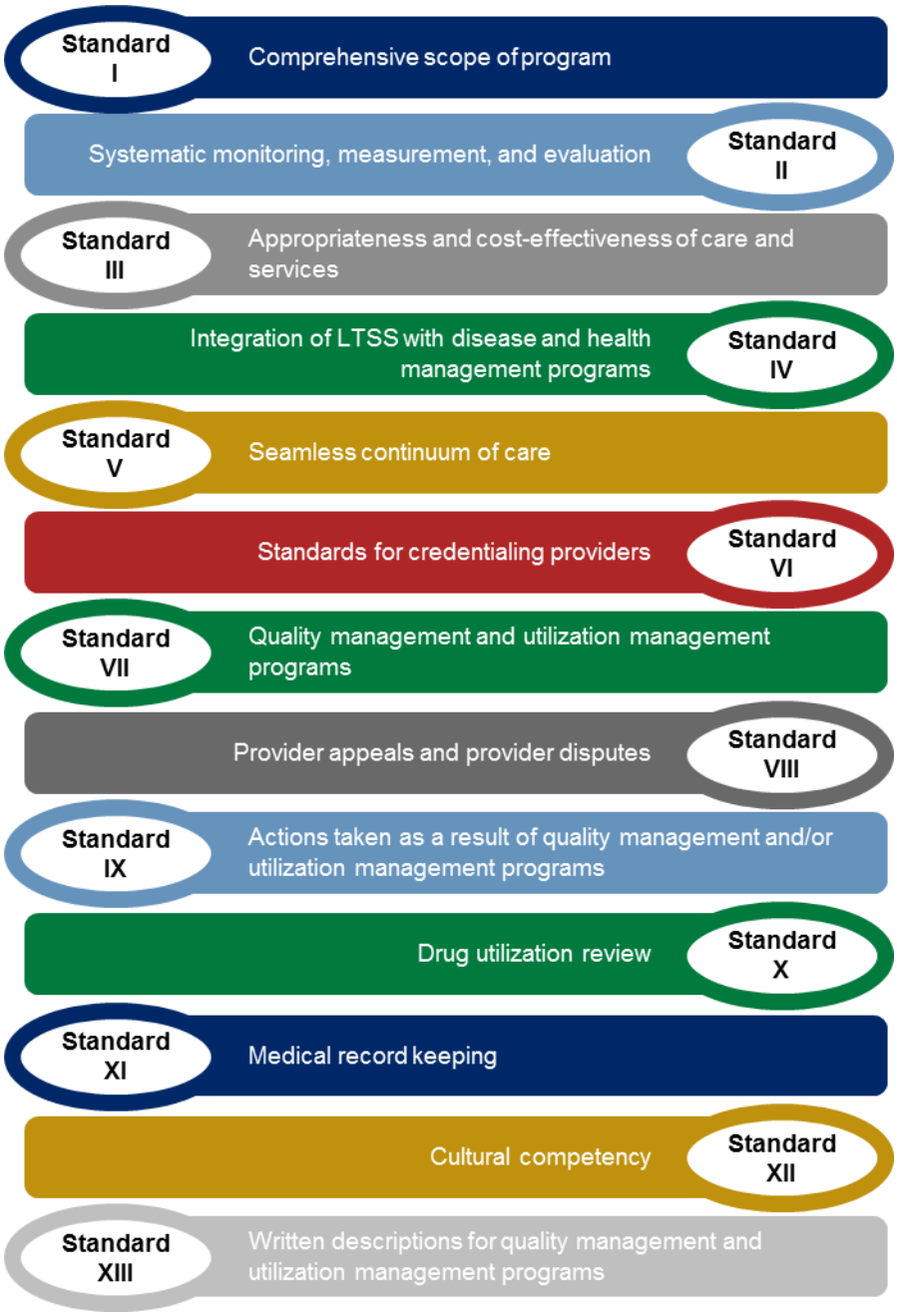
Protection from Abuse, Neglect, and Exploitation

CHC-MCOs will be required to adopt policies to protect against and detect abuse, neglect, and exploitation. CHC-MCOs will be required to train their network providers in mandatory reporting requirements for any instance of abuse, neglect or exploitation. CHC-MCOs will also be required to notify Adult Protective Services and Older Adult Protective Services of any situations that are reportable to those systems under their respective statutes. CHC-MCOs will also be required to comply and ensure that their staff and providers comply with applicable laws, regulations, and policies surrounding abuse and criminal background checks.

CHC-MCOs will be required to implement a critical incident reporting and management system for incidents that occur in LTSS delivery settings including nursing facilities and community-based settings. CHC-MCOs will be required to track and analyze critical incidents to identify and address potential and actual quality of care and/or health and safety issues, identify trends and patterns, identify opportunities for improvement, and develop and implement strategies to reduce the occurrence of incidents and improve the quality of services. CHC-MCOs will be required to report all critical incidents to the commonwealth.

Critical incidents include, but are not limited to, incidents listed on page 43 in connection with Enterprise Incident Management.

Appendix C: Standards for the Quality Management and Utilization Management Programs of CHC-MCOs



Standard I: The scope of the programs must be comprehensive, allow for improvement and be consistent with the commonwealth's goals related to access, availability, and quality of care. Distinct policies and procedures regarding LTSS services must specify the responsibilities and scope of the authority of service coordinators in authorizing LTSS.

Standard II: The programs must include methodologies that allow for objective and systematic monitoring, measurement, and evaluation of the quality and appropriateness of care and services.

Standard III: The programs must objectively and systematically monitor and evaluate the appropriateness and cost-effectiveness of care and services provided to participants through utilization review activities with a focus on identifying and correcting instances and patterns of overutilization, underutilization, and misutilization.

Standard IV: The program must have mechanisms for integration of LTSS with disease and health management programs that rely on wellness promotion, prevention of complications, and treatment of chronic conditions for participants.

Standard V: The programs must ensure that participants receive seamless, continuous, and appropriate care throughout the continuum of care, by means of coordination of care, benefits, and quality improvement activities.

Standard VI: The programs must have standards for credentialing and recredentialing providers to determine whether physicians, other health care providers, and other LTSS providers who provide services in the commonwealth and are under contract with the CHC-MCO are qualified to perform their services.

Standard VII: The programs must contain policies and procedures that describe the scope of the QM and UM programs, mechanisms, and information sources used to make determinations of medical necessity.

Standard VIII: The CHC-MCO must have a mechanism in place for provider appeals and disputes.

Standard IX: The CHC-MCO must ensure that findings, conclusions, recommendations and actions taken as a result of QM and UM program activities are documented and reported to appropriate individuals within the plan for use in other management activities.

Standard X: The CHC-MCO must have written policies and procedures for conducting prospective and retrospective drug utilization review (DUR) that meet DHS DUR guidelines and federal requirements.

Standard XI: The CHC-MCO must have written standards for medical record keeping.

Standard XII: The QM and UM programs must demonstrate a commitment to ensuring that participants are treated in a manner that is culturally competent, acknowledges their defined rights, and respects and honors personal choices.

Standard XIII: The CHC-MCO must maintain systems, which document implementation of the written QM and UM program descriptions.

Appendix D. Information Technology Requirements Overview

Information technology (IT) requirements will be consistent with those in HealthChoices and will include, but are not limited to, the following:

Eligibility Reporting

The commonwealth will provide a Monthly 834 Benefit Enrollment and Maintenance file for each CHC-MCO on the second to last Saturday of the month, which will be sent to the CHC-MCOs by Monday at 6:00 a.m. The file will contain the MA Eligibility Period, CHC-MCO coverage, BH-MCO coverage and other participant demographic information. It will contain only one record for each managed care participant where the member is both MA and CHC Managed Care eligible at some point in the following month. The CHC-MCO must reconcile this membership file against its internal membership information and capitation payment file and notify the commonwealth of any discrepancies found within 30 business days, in order to resolve problems. Participants not included in this file will still be the responsibility of the CHC-MCO until their MA and MCO termination date.

The commonwealth will provide to the CHC-MCO a Daily 834 Benefit Enrollment and Maintenance File that contains record(s) for each managed care participant where data for that participant has changed that day. The file will contain add, termination and change records. The record can contain demographic changes, eligibility changes, enrollment changes, members enrolled through the automatic assignment process, and third party liability (TPL) information. A separate record for CHC-MCO and BH-MCO will be created and sent as needed. The MCOs must process this file within 24 hours of receipt and prior to any Daily 834 file received after.

Encounter Data Reporting

The CHC-MCO must record for internal use and submit to the commonwealth encounter data. Encounter data consists of a separate record each time a participant has an encounter with any provider including medical and LTSS providers, and including participant-directed services. A service rendered under the agreement is considered an encounter regardless of whether or not it has an associated claim. The CHC-MCO shall only submit encounter data for participants enrolled in the CHC-MCO on the date of service and not submit any duplicate records. The CHC-MCO must maintain appropriate systems and mechanisms to obtain all necessary data from its providers to ensure its ability to comply with the encounter data reporting requirements. The failure

of a provider or subcontractor to provide the CHC-MCO with necessary encounter data does not excuse the CHC-MCO's noncompliance with this requirement.

The CHC-MCO will be given a minimum of 60 days notification of any new edits or changes that the commonwealth intends to implement regarding Encounter Data.

Encounter data files must be provided in the following HIPAA transactions:

- 837 – Professional
- 837P – Drug
- 837I – Inpatient
- 837I – Outpatient
- 837I – Long Term Care
- 837I – Outpatient Drug
- 837 – Dental
- NCPDP batch files

All encounter records except pharmacy transactions must be submitted and determined acceptable by the commonwealth on or before the last calendar day of the third month after the payment/adjudication calendar month in which the CHC-MCO paid/adjudicated the claim. Pharmacy transactions must be submitted and approved in PROMISe™ within 30 calendar days following the adjudication date.

Encounter records that are denied due to commonwealth edits are returned to the CHC-MCO and must be corrected. Denied encounter records must be resubmitted as "new" encounter records if appropriate and within the timeframe referenced above.

Encounter submissions, corrections and resubmissions sent to the commonwealth are considered acceptable when they pass all commonwealth edits.

The CHC-MCO must adhere to the file size and format specifications provided by the commonwealth. CHC-MCOs must also adhere to the encounter file submission schedule provided by the commonwealth.

The encounter data system must have a mechanism in place to receive and process the U277 and NCPDP response files; and to store the PROMISe™ ICN associated with each processed Encounter Data record returned on the files.

Capitation Payment Transactions

The 820 transaction will be used for fund transfers associated with capitation payments.

Enterprise Incident Management (EIM)

CHC-MCOs and their network providers and subcontractors will be required to submit critical events or incidents via a standard file transaction that will be incorporated into the Enterprise Incident Management System. The following are considered critical incidents:

- Death (other than by natural causes);
- Serious injury that results in emergency room visits, hospitalizations, or death;
- Hospitalization except in certain cases, such as hospital stays that were planned in advance;
- Provider and staff misconduct, including deliberate, willful, unlawful, or dishonest activities;
- Abuse, which includes the infliction of injury, unreasonable confinement, intimidation, punishment, mental anguish, or sexual abuse of a participant. Types of abuse include, but not necessarily limited to:
  - Physical abuse, defined as a physical act by an individual that may cause physical injury to a participant;
  - Psychological abuse, defined as an act, other than verbal, that may inflict emotional harm, invoke fear, and/or humiliate, intimidate, degrade or demean a participant;
  - Sexual abuse, defined as an act or attempted act, such as rape, incest, sexual molestation, sexual exploitation, or sexual harassment and/or inappropriate or unwanted touching of a participant; and
  - Verbal abuse, defined as using words to threaten, coerce, intimidate, degrade, demean, harass, or humiliate a participant;
- Neglect, which includes the failure to provide a participant the reasonable care that he or she requires, including, but not limited to food, clothing, shelter, medical care, personal hygiene, and protection from harm. Seclusion, which is the involuntary confinement of an individual alone in a room or an area from which the individual is physically prevented from having contact with others or leaving, is a form of neglect;
- Exploitation, which includes the act of depriving, defrauding, or otherwise obtaining the personal property from a participant in an unjust, or cruel manner, against one's will, or without one's consent, or knowledge for the benefit of self or others;

- Restraint, which includes any physical, chemical or mechanical intervention that is used to control acute, episodic behavior that restricts the movement or function of the individual or a portion of the individual's body. Use of restraints and seclusion are both restrictive interventions, which are actions or procedures that limit an individual's movement, a person's access to other individuals, locations or activities, or restricts participant rights;
- Service interruption, which includes any event that results in the participant's inability to receive services that places his or her health and or safety at risk. This includes involuntary termination by the provider agency, and failure of the participant's back-up plan. If these events occur, the provider agency must have a plan for temporary stabilization; and
- Medication errors that that result in hospitalization, an emergency room visit or other medical intervention.