

Community HealthChoices Questions and Answers Document

Table of Contents

Instructions: Click on the topic below to be taken automatically to the associated section of this document. To automatically return to the table of contents, click on any section title within the document.

Provider Related Questions and Answers

Behavioral Health
Benefits
CHC Assessment Process
CHC Transition
Complaints and Grievances
Continuity of Care
Electronic Visit Verification (EVV)
Eligibility Verification System (EVS)
General CHC Related
Incident Management
Independent Enrollment Broker (IEB)
Medicare
Network Adequacy
Organized Health Care Delivery System (OHCDS)
Participant Eligibility
Participant Enrollment
Provider Billing
Provider Disputes
Provider Education
Provider Enrollment
Provider Rates
Quality and Oversight
Service Coordination

Participant Related Questions and Answers

General CHC Participant Related
Southwest CHC Participant Education Meetings

Behavioral Health

Q1. Will CHC-MCOs assist inpatient behavioral health facilities with discharges to nursing homes and/or the next appropriate level of care?

- A. CHC-MCOs are required to provide coordination of long-term services and supports, Medicare services, physical health services, and behavioral health services. This would include working to transition participants from one setting to another more appropriate setting based on their assessed needs.

Q2. What will be done to address the needs of individuals residing in nursing facilities with long-term needs with symptoms of behavioral health disorders?

- A. CHC-MCOs will be required to coordinate care with Pennsylvania’s behavioral health managed care organizations to ensure that the needs of participants with behavioral health issues are addressed, regardless of where they reside.

Q3. What does primary care physician coordination of behavioral health services mean? How does this change a participant’s ability to directly access behavioral health services?

- A. Participants will still access behavioral health services directly through their Behavioral Health managed care organizations (BH-MCOs). The BH-MCOs and CHC-MCOs will work together to make sure participants have comprehensive care.

CHC-MCOs are responsible for coordinating all Medicaid funded long-term services and supports (LTSS) and physical health services. They are also responsible to coordinate with the BH-MCOs for individuals receiving behavioral health services and with the participant’s Medicare plan for Medicare-funded services. Both physical healthcare and long-term services and supports are provided by CHC-MCOs. To access behavioral health services, CHC participants will go through BH-MCO or directly access services with participating MA providers.

Primary care physician coordination of behavioral health services means the physician coordinates with any behavioral health providers delivering services to participants, and the physician considers any behavioral health treatment when developing a plan of care.

Q4. Have the CHC-MCOs identified their behavioral health liaisons?

- A. Yes, interested parties should contact the CHC-MCOs for more information on their behavioral health coordinator.

Q5. Does the BH-MCO or CHC-MCO cover the counseling component and medication for methadone treatment?

- A. **Revised February 14, 2020** – The BH-MCO will cover Mental Health Counseling for participants undergoing methadone treatment. The BH-MCO is also responsible for the payment of methadone when used in the treatment of substance abuse disorders and when prescribed and dispensed by BH-MCO service providers. Otherwise, unless financial responsibility is otherwise assigned, all covered outpatient drugs are the payment responsibility of the participant’s CHC-MCO.

Q6. Are behavioral health (BH) services part of the nursing home rates or will BH providers be reimbursed by the CHC-MCOs directly for BH services provided to nursing home residents?

- A. Under CHC, BH services are not part of the nursing home rates. BH providers will be reimbursed by the BH-MCOs for medically necessary BH services provided to nursing home residents, as authorized by the BH-MCO.

Q7. What happens if a CHC participant loses coverage with their Behavioral Health-MCO (BH-MCO)?

- A. **Revised December 2, 2019** – Enrollment in CHC automatically triggers behavioral health managed care coverage, so CHC participants should not lose coverage in their BH-MCO. The BH-MCOs are responsible to provide all necessary behavioral health services. The CHC-MCOs are not responsible to provide behavioral health coverage for CHC participants except the following three services for LTSS participants receiving home and community-based waiver services:
- Counseling services
 - Cognitive rehabilitation therapy
 - Behavior therapy services

These services are provided under CHC only when they are not covered, or have been exhausted, under Medicare, the Medicaid State Plan (including BH-MCO) or private insurance.

Benefits

Q1. Can more specifics be provided on what behavioral health (BH) services nursing facilities might have available to residents?

- A. All CHC participants will be covered by BH managed care through the existing BH-managed care organizations (MCO).

If an individual in a nursing facility is determined to be in need of specialized BH services, as determined by the pre-admission screening and resident review (PASRR) program, then those services will be managed by the BH-MCO. The mental health services provided through the BH-MCOs will be specified in an individualized plan of care that is developed for the individual and supervised by an interdisciplinary team. These services will be provided at a higher intensity and frequency than the mental health services which are typically provided by the nursing facility. Some examples include partial hospitalization, psychiatric outpatient clinic, mental health crisis intervention, mobile mental health treatment, peer support services, and mental health targeted case management.

Q2. For nursing facility residents, will the CHC-MCO or the Department of Human Services (DHS) approve the exceptional durable medical equipment (DME) requests, and who is responsible for maintaining the exceptional DME list?

- A. **Revised December 2, 2019** – The CHC-MCOs must provide and have a process for approving exceptional DME. DHS will continue to publish an annual list of exceptional DME by notice in the Pennsylvania Bulletin each July.

Q3. What is the process for the approval of exceptional durable medical equipment (DME) requests for nursing facility residents?

- A. **Revised December 2, 2019** – The CHC-MCOs must provide and have a process for approving exceptional DME for nursing facility residents, as listed in Exhibit A of the CHC Agreement.

The CHC-MCOs must provide a separate payment for exceptional DME in addition to the nursing facility per diem rate. The amount of the additional payment authorized is based upon the necessary, reasonable, and prudent cost of the exceptional DME. Purchased equipment will belong to the participant.

Q4. For nursing facility residents, will the CHC-MCO honor an existing exceptional durable medical equipment (DME) grant?

- A. **Revised December 2, 2019** – DHS will be responsible for follow-up and payment for any wheelchairs or augmentative communication devices approved prior to the date of CHC implementation in each CHC zone. Any bed or mattress rentals that were approved prior to the date of CHC implementation but continue in the new year will be transferred to the CHC-MCO for follow-up and payment. Any requests received prior to the date of CHC implementation that have not been reviewed by the Department will be transitioned to the CHC- MCO for review and payment.

Q5. Will there be coverage for dentures, glasses and hearing aids under CHC?

- A. Dentures and eyeglasses for individuals with aphakia are covered physical health services under CHC. Hearing aides are covered through the CHC 1915(c) home and community-based (HCBS) waiver under Specialized Medical Equipment and Supplies.

Individuals may want to contact the CHC-MCO to ask if the CHC-MCO offers dentures, eyeglasses or hearing aids as value-added services.

Q6. What is the difference between adult daily living services and personal assistance services (PAS) under CHC?

- A. Adult Daily Living services are designed to assist participants in meeting, at a minimum, personal care, social, nutritional and therapeutic needs. Adult Daily Living services are generally furnished for four or more hours per day on a regularly scheduled basis for one or more days per week, or as specified in the service plan, in a non-institutional, community-based center encompassing both health and social services needed to ensure the optimal functioning of the participant. Adult Daily Living includes two components: Basic Adult Daily Living services and Enhanced Adult Daily Living services.

PAS primarily provide hands-on assistance to participants to enable them to integrate more fully into the community and ensure the health, welfare and safety of the participant. PAS, which are generally provided to participants in their homes and communities, are aimed at assisting participants to complete tasks of daily living that would be performed independently if they had no disability.

A participant's need for Adult Daily Living Services and PAS are determined by an assessment conducted by the CHC-MCOs, in accordance with DHS requirements and specified in the participant's PCSP.

Q7. How will hospice services in a nursing facility be provided and reimbursed under CHC?

- A. The CHC-MCOs must provide hospice and use certified hospice providers in accordance with 42 C.F.R. Subpart G. CHC-MCOs will be required to contract with Medical Assistance (MA) enrolled hospice providers to provide these services. To be an MA enrolled provider, the hospice must be a Medicare certified provider. As with other Medicare-covered services, CHC participants will be required to exhaust their available Medicare hospice benefits. The CHC-MCO must coordinate with hospice providers for dual eligible participants who are receiving hospice through their Medicare coverage. Hospice provided to participants by Medicare-approved hospice providers is directly reimbursed by Medicare.

Under CHC, the hospice provider and nursing facility will bill the CHC-MCO for services rendered. The hospice provider will bill the CHC-MCO for any hospice services rendered and nursing facilities will bill the CHC-MCO for the resident's room and board.

Q8. Are HCBS specialized medical equipment and supplies covered under CHC?

- A. The CHC-MCO must provide HCBS specialized medical equipment and supplies. Specialized medical equipment and supplies are services or items that provide direct medical or remedial benefit to the participant and are directly related to a participant's disability.

Specialized medical equipment and supplies includes: devices, controls or appliances, specified in the PCSP, that enable participants to increase, maintain or improve their ability to perform activities of daily living; equipment repair and maintenance, unless covered by the manufacturer warranty; items that exceed the limits set for Medicaid state plan covered services; and rental equipment. In certain circumstances, needs for equipment or supplies may be time limited.

Q9. Can you provide a list of covered services that are provided under CHC?

- A. **Revised December 2, 2019** – Exhibit A of the CHC Agreement provides a list of the services covered under CHC.

Exhibit A can be viewed at the following link:

<http://www.healthchoices.pa.gov/providers/resources/publications/community/supporting-documents/index.htm>

Q10. What specific home adaptations are covered under CHC?

- A. **Revised December 2, 2019** – Home adaptations are physical adaptations to the private residence of the participant to ensure the health, welfare and safety of the participant and enable the participant to function with greater independence in the home. Home adaptations consist of installation, repair, maintenance, permits, necessary inspections, and extended warranties for the adaptations. Appendix C-1/C-3 of the CHC HCBS waiver provides more information, including a list of covered adaptations. Home adaptations must be specified in the participant's PCSP and determined necessary in accordance with the participant's assessment.

Q11. What types of assistive technology will be covered under CHC?

- A. **Revised December 2, 2019** – Assistive Technology service is an item, piece of equipment or product system — whether acquired commercially, modified or customized – that is needed by the participant to increase, maintain or improve a participant's functioning in communication, self-help, self-direction, life supports or adaptive capabilities. Appendix C-1/C-3 of the CHC HCBS waiver includes a list of covered assistive technology items. Assistive Technology service must be specified in the participant's PCSP and determined necessary in accordance with the participant's assessment.

Q12. Will the CHC-MCO be providing non-medical transportation?

- A. **Revised December 2, 2019** – CHC-MCOs are required to provide non-medical transportation to long-term services and supports (LTSS) participants. Appendix C-1/C-3 of the CHC HCBS waiver and the CHC Transportation Fact Sheet provide more information on non-medical transportation under CHC.

The CHC HCBS waiver can be viewed at the following link:

http://www.healthchoices.pa.gov/cs/groups/webcontent/documents/document/c_293207.pdf

The CHC Transportation Fact Sheet can be viewed at:

http://www.healthchoices.pa.gov/cs/groups/webcontent/documents/document/c_282997.pdf

Q13. How will CHC-MCOs handle Personal Emergency Response Systems (PERS)?

- A. The CHC-MCOs must cover PERS. PERS are subject to the continuity-of-care provision, which allows PERS providers to continue as a subcontractor to a service coordination entity (SCE).

After the continuity-of-care time period, CHC-MCOs can determine their provider network. Providers must agree to contractual terms and meet CHC-MCO participation requirements. PERS providers who are currently enrolled as a subcontractor to an SCE must enroll as a MA provider with the Office of Long-Term Living and contract with CHC-MCOs to provide services to CHC participants.

Q14. What nursing facility supplemental payments are included in the capitated rate and are any remaining in Fee-for-Service (FFS)?

- A. Supplemental payments included in the capitation rate include: exceptional durable medical equipment, assessment-related allowable cost for nonpublic nursing facilities (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.

Supplemental payments remaining in FFS include: Health Care-associated Infection (HAI) and any legislative adds, such as nonpublic Medical Assistance Day One Incentive (MDOI).

Q15. What is CHC's impact on Third Party Liability (TPL)?

- A. Under CHC, the MA program will continue to remain the payer of last resort. All forms of TPL must be exhausted before CHC-MCOs will pay for a covered service or item. Providers remain responsible to check the Eligibility Verification System (EVS) at the time of service. Providers should ask participants to present, at minimum, their ACCESS card and CHC-MCO insurance card.

Providers will bill the participant's CHC-MCO for services provided. If the participant has a TPL, including Medicare, providers must bill the TPL first for payment of eligible services and obtain an Explanation of Benefits (EOB) from the primary insurer. Once the TPL has paid or denied the claim, providers may bill the CHC-MCOs for the remainder of the claim.

Providers may not balance-bill participants when Medicaid, Medicare, or another form of TPL does not cover the entire billed amount for a service delivered.

Q16. Will health and wellness education be available under CHC?

- A. The CHC-MCO must provide health and wellness opportunities for participants, such as providing classes, support groups, and workshops; disseminating educational materials and resources; and providing website, email, or mobile application communications. Topics to be addressed will include but not be limited to heart attack and stroke prevention, asthma, living with chronic conditions, back care, stress management, healthy eating and weight management, oral hygiene, and osteoporosis. The CHC-MCO may also include annual or other preventive care reminders and caregiver resources. The Department of Human Services encourages CHC-MCOs to identify regional community health education opportunities, improve outreach and communication with Participants and community-based organizations, and actively promote healthy lifestyles as well as disease prevention and health promotion.

Q17. For Continuing Care Retirement Communities (CCRC), can home and community-based services be provided in personal care and independent living settings?

- A. HCBS can be provided in independent living settings of CCRCs provided that the CCRC contract and fees paid by the participant do not cover HCBS services.

Current residents of personal care homes (PCHs) who are receiving HCBS may continue to receive services in that setting. Nursing facility ineligible (NFI) duals participants, who are living in PCHs, can also remain in their PCHs and receive physical health services under CHC. Once they need long-term services and supports, these participants must transition to another living arrangement to receive HCBS, unless they are receiving residential habilitation services in a 42 C.F.R. § 441.301 compliant setting.

Q18. Will CHC services be limited?

- A. **Revised January 26, 2018** – CHC will not change current service limitations. Please refer to the Office of Medical Assistance Programs (OMAP) Healthcare Benefits Packages Reference Chart for more information: <https://www.dhs.pa.gov/docs/For-Providers/Pages/Bulletin-Search.aspx>.

All CHC services must be medically necessary and long-term services and supports must be identified in the standardized needs assessment and specified in the participant's PCSP.

Q19. Aside from state mandated services, are CHC-MCO's permitted to offer expanded/value added services?

- A. **Revised May 1, 2018** – As permitted by Section V.A.4 of the CHC Agreement, Expanded Services and Value-Added Services, the CHC-MCO may offer participants expanded or value-added services. If offered, the CHC-MCO may feature such services in approved outreach materials. Adding or changing value-added services requires modification of written materials and is subject to approval from the Department.

For more information, please visit <https://www.enrollchc.com/>. Click on "Choose" then "Compare Plans" to compare CHC Health Plan information.

Q20. Are there any requirements in CHC for participant self-directed family/caregiver worker education?

- A. The Financial Management Services (FMS) vendor is responsible for direct care worker (DCW) training. The FMS vendor must receive prior approval from the Office of Long-Term Living of the content of DCW pre-service orientation. Pre-service orientation must, at a minimum, cover the following topics: operational procedures and paperwork, roles and responsibilities in independent living system, workplace safety, transparency and fraud, eligibility for public benefits, and worker rights and responsibilities.

The FMS vendor must provide DCW pre-service orientation that provides a basic understanding of the functions and requirements of the participant directed programs, including the role and responsibility of the participants as the employer to direct, supervise, train and select the DCW.

The FMS vendor must have experience in supporting the training and orientation of home caregivers such as DCWs, in labor management training partnerships, and in the development of relevant orientation curriculum and have statewide capacity to implement a consistent, timely pre-service orientation program. The FMS Vendor may use a subcontractor to satisfy the pre-service orientation experience requirements.

Questions Added on December 2, 2019

Q21. Will public transportation providers such as Red Rose and Rabbit Transit continue to be providers under CHC?

- A. For medical transportation, there will be no change under CHC. Public Transportation providers can continue to provide non-emergency medical transportation (NEMT) services to MA recipients, including CHC participants, through the Medical Assistance Transportation Program (MATP).

For non-medical transportation, these providers must meet DHS qualifications for transportation services and be enrolled with a CHC-MCO's transportation broker.

Q22. Will DCWs be able to provide transportation when the participant needs assistance to and from a doctor's appointment?

- A. Participants must utilize MATP for medical appointments. DCWs may continue to accompany a participant to medical appointments when the need is documented on the participant's PCSP. SCs should contact the CHC-MCOs to discuss the provision of NEMT.

The CHC Transportation Fact Sheet outlines transportation options and how transportation is billed and coordinated for CHC participants based on where the participant resides and the type of transportation needed, and can be accessed at:

http://www.healthchoices.pa.gov/cs/groups/webcontent/documents/document/c_282997.pdf

Q23. Can DCWs still transport consumers to non-medical activities?

- A. DCWs may continue to provide transportation incidental to PAS for non-medical activities. Although costs incurred while providing transportation, such as mileage, cannot be billed or reimbursed as PAS, the time a worker spends driving and accompanying a participant on these types of outings can be billed as PAS when the need is documented in the participant's PCSP. DCWs may not bill for PAS and non-medical transportation services simultaneously. DCWs may provide and bill for non-medical transportation only if they meet DHS qualifications for transportation services and are enrolled with a CHC-MCO's transportation broker.

Q24. Can a DCW transport a CHC participant to a medical appointment when it's faster or more convenient than using MATP?

- A. No. DCWs must utilize a third-party transportation vendor, such as MATP or the CHC-MCO's transportation broker for payment of NEMT whenever possible. These vendors have a responsibility to provide NEMT in specific situations, and convenience is not a valid reason for not utilizing these vendors.

More information on CHC-MCO and MATP responsibility for CHC transportation can be found at http://www.healthchoices.pa.gov/cs/groups/webcontent/documents/document/c_282997.pdf

Please also see Q54 in the Provider Billing section of this document.

Q25. Can DCWs run errands without the participant (food shopping, picking up pills, etc.)?

- A. DCWs may continue to run errands for the participant and bill as PAS for the time a worker spends driving and carrying out these types of activities when the need is documented in the participant's PCSP. Cost incurred by DCWs while performing these tasks are not reimbursable under the CHC HCBS waiver as PAS. SCs should contact the CHC-MCOs to discuss the provision of non-medical transportation.

Q26. Do PCSPs have to be sent to the State for approval?

- A. No. The CHC-MCOs are responsible for review and approval PCSPs. SCEs that have subcontracted with a CHC-MCO should discuss this topic further with the CHC-MCO.

Q27. Is TPL assumed when a primary payer such as Medicare does not cover the service such as cognitive rehabilitation therapy, residential habilitation and structured day services?

- A. If the participant has a TPL, including Medicare, that covers a service, providers must bill the TPL first for payment of the covered service and obtain an EOB from the TPL. Once the TPL has paid or denied the claim, providers may then bill CHC-MCOs.

Q28. Are the CHC-MCOs reviewing PCSPs to identify individuals who may benefit from cognitive rehabilitation therapy?

- A. The CHC-MCOs are required to use the interRAI™ Home Care (HC) assessment tool to perform needs assessments and reassessments of HCBS LTSS participants' physical health, BH, social, psychosocial, environmental, caregiver, LTSS, and other needs, as well as preferences, goals, housing, and informal supports. CHC-MCO staff or their contracted SCs will use the information gathered during this process to develop or revise the participant's PCSP.

All CHC services must be medically necessary and LTSS must be identified in the standardized needs assessment and specified in the participant's PCSP.

Q29. What are the dollar limits for home adaptations?

- A. There are no dollar limits for home adaptations, however the service must be provided in the most cost-effective manner in accordance with the CHC HCBS waiver. All CHC services must be medically necessary and LTSS must be identified in the standardized needs assessment and specified in the participant's PCSP.

CHC Assessment Process

Q1. Who will perform the level of care assessment, the participants needs assessment and redeterminations? What will the process be for those residing in nursing facilities?

- A. DHS contracts with an Independent Assessment Entity (IAE) to conduct the initial level of care determinations for individuals seeking long-term services and supports (LTSS). The IAE is subcontracting with local Area Agencies on Aging to do the initial level of care determinations. CHC-MCOs are responsible for using the interRAI™ Home Care (HC) tool to perform comprehensive needs assessments and reassessments of participants receiving home and community-based LTSS no more than 12 months following the most recent prior comprehensive needs assessment. These comprehensive assessments must be conducted at least once every 12 months, unless a “trigger event” occurs, which would require a more frequent assessment. Trigger events are defined in the 1915(c) home and community-based waiver and CHC Agreement including but not limited to a hospitalization or change in functional status. The data collected by the CHC-MCOs on the interRAI™ tool during the comprehensive needs assessments will be provided to the IAE to use in making the annual redeterminations for functional eligibility. The process for the initial level of care determination is the same for nursing facility residents and those residing in the community. The Minimum Data Set (MDS) 3.0 is the assessment tool used in nursing facilities.

Q2. Will the assessment process for the OPTIONS program change after CHC is implemented?

- A. No, the assessment process will not change for the OPTIONS program after CHC implementation. Local Area Agencies on Aging will continue to perform the level of care assessment for OPTIONS.

Q3. With the Centers for Medicare and Medicaid Services (CMS) currently focusing on similar data collection across the continuum of care, how does the interRAI™ HC assessment fit?

- A. All CHC-MCOs are required to use the interRAI™ HC assessment tool to perform needs assessments and reassessments of HCBS LTSS participants’ physical health, behavioral health, social, psychosocial, environmental, caregiver, LTSS, and other needs, as well as preferences, goals, housing, and informal supports. While CMS data was not used in developing the interRAI™ HC assessment tool, it is currently used worldwide and in many states, and is consistent with the information collected on the Minimum Data Set (MDS) 3.0, the assessment tool used in nursing facilities.

Q4. Will clinical eligibility be reviewed periodically?

- A. **Revised December 2, 2019.** Please see Q1, Q5 and Q6 in the CHC Assessment Process section of this document for more information.

Q5. With reassessments being completed every 12 months or based on trigger events, what are the requirements for CHC-MCO contacts (phone and in-person) with participants?

- A. CHC-MCOs must conduct an in-person comprehensive needs assessment of all NFCE participants, as well as any participant who has an immediate need for services, unmet needs, service gaps, or a need for service coordination. The CHC-MCO must perform a comprehensive needs reassessment every 12 months unless a trigger event occurs. If a trigger event occurs, the CHC-MCO must complete a reassessment as expeditiously as possible in accordance with the circumstances and as clinically indicated by the participant's health status and needs, but in no case more than 14 days after the occurrence of the trigger event. Trigger events are defined in the 1915(c) home and community-based waiver and CHC Agreement including but not limited to a hospitalization or change in functional status.

In addition, if the CHC-MCO identifies that a Participant has not been receiving services to assist with activities of daily living as indicated on the service plan for a period of 5 days or more, and the suspension of services was not pre-planned, the CHC-MCO must communicate with the Participant to determine the reason for the service suspension within 24 hours of identifying the issue. If, after communicating, the CHC-MCO determined that the Participant's health status or needs have changed, then the CHC-MCO must conduct a comprehensive needs assessment within 14 days of identifying the issue.

The CHC-MCOs must annually submit and obtain Department approval of its service coordination staffing plan including the required frequency of in-person service coordinator contact.

Q6. Will a service coordinator conduct the annual comprehensive needs assessment?

- A. The CHC-MCO will determine if the comprehensive needs assessment is done by CHC-MCO staff or by a contracted service coordinator. Service coordination entities that have subcontracted with a CHC-MCO should discuss this topic with the CHC-MCO.

Q7. How does the Functional Eligibility Determination (FED) comply with nursing facility clinically eligible when it has no medical questions? What role do physicians play in the FED?

- A. Determination of whether an individual is nursing facility clinically eligible (NFCE) requires input from an individual's physician in the form of a physician certification. The physician's certification form indicates the physician's diagnosis and clinical eligibility recommendation. The FED tool is a determination of an individual's long-term care needs, and focuses on whether the individual needs help with essential activities of daily living, such as moving around the house and eating. DHS uses both the physician's medical certification and the FED tool to determine whether an individual is NFCE.

Q8. If the CHC-MCO makes a referral to the Independent Enrollment Broker (IEB), is the CHC-MCO required to have a process in place to follow that referral from phone call through completed enrollment?

- A. The CHC-MCO is not required to have a process in place to monitor an individual's enrollment application however, if the CHC-MCO is a COMPASS community partner, then the CHC-MCO will have the ability to track an individual's application.

Q9. When will the FED and needs assessment be available to the service coordination entities to review?

- A. The interRAI™ HC assessment tool, which will be used for needs assessments and the annual level of care redetermination, will be available to service coordinators when CHC is implemented in each respective zone.

Q10. What qualifications will the person conducting comprehensive needs assessments and reassessments have?

- A. Service Coordinators are responsible for conducting the comprehensive needs assessments and reassessments. Service coordinators must: (1) be a Registered Nurse (RN); or (2) have a Bachelor's degree in social work, psychology, or another related fields with practicum experience; or (3) have at least three (3) or more years of experience in a social service or healthcare related setting. Service Coordinators hired prior to the CHC zone implementation date must have the qualifications and standards proposed by the CHC-MCOs and approved by the Department.

Q11. When participants switch to a different CHC-MCO, their service coordinator will also change. Does this mean services will be reassessed?

- A. The current CHC-MCO will transfer a participant's information to the new CHC-MCO. The new CHC-MCO may conduct a reassessment based on its review of the previous information and discussion with the participant. Some CHC-MCOs may gather additional information in their assessments that supplements information from the standard assessment tool all CHC-MCOs must use. In that case, participants may be reassessed or asked supplemental questions.

Q12. What are expectations around the timeframes for the various assessments which are required?

- A. The IEB is responsible for facilitating enrollment in CHC. The FED, which determines whether a participant is clinically eligible for LTSS, will be conducted by the IAE. After an individual submits their application for LTSS enrollment to the IEB, the IEB has three days to notify the IAE of the need for an FED. The FED must be completed within ten business days of a request from the IEB. The IAE must transmit the results back to the IEB within 15 days of the request.

Once a participant is enrolled in a CHC-MCO, the CHC-MCO must complete an in-person comprehensive needs assessment in accordance with the following timeframes:

1. For nursing facility clinically eligible participants who are not receiving long-term services and supports on their enrollment date, no later than five business days from the start date.
2. For dual eligible participants identified by the IEB as having a need for immediate services, no later than five business days from the start date.
3. For participants who are identified as having unmet needs, service gaps, or a need for service coordination, no later than 15 business days from the date the CHC-MCO is aware of the unmet needs, service gaps, or need for service coordination.
4. For participants with existing Person-Centered Service Plans (PCSP) in place on the start date, within 180 days of the start date, except for participants who are due for a level of care redetermination prior to the 180th day following the start date, within five business days of the level of care redetermination.
5. When requested by a participant or a participant's designee or family member, no later than 15 days from the request.

The CHC-MCO must conduct a comprehensive needs reassessment of NFCE participants annually, unless a trigger event (such as a hospitalization, change in caregivers, or change in home setting) occurs. If a trigger event occurs, the CHC-MCO must complete a reassessment as quickly as possible, given the circumstances and the Participant's health status and needs, but in no case more than 14 days after a trigger event.

Q13. Will the Case Management Instrument (CMI) for participants receiving HCBS be replaced with the FED tool or will the CHC-MCOs have their own assessment tool for use at the annual reassessment or to assess a change in need?

- A. The Department of Human Services uses the FED to determine whether an LTSS applicant meets the required level of care and is clinically eligible for LTSS. The IAE completes the initial FED.

For participants who are clinically eligible for LTSS (“NFCE”) and enrolled in a CHC-MCO, the CHC-MCO will conduct the initial comprehensive needs assessments and reassessments using a tool designated by DHS. DHS selected the interRAI™ HC assessment tool for needs assessments and reassessments. Reassessments are conducted once every 12 months or when a trigger event, (such as a hospitalization or change in functional status) occurs.

As required by federal law, annual redeterminations of clinical eligibility will still be conducted under CHC. The CHC-MCO will transmit the information gathered using the interRAI™ HC tool during the needs reassessment to the IAE for the annual eligibility redetermination. The IAE will make the redetermination decision, subject to oversight by DHS.

Q14. What was the outcome of the assessor's training held in April of 2017?

- A. **Revised December 2, 2019.** The assessors who participated in the testing phase of the FED development were trained in April of 2017. The training was successful in informing and preparing the assessors to administer the new FED tool. All assessors were trained prior to the implementation of the FED in April 2019.

Questions Added on December 2, 2019

Q15. Can you describe your anticipated procedure for assuring annual FED assessments are done on a timely basis?

- A. As required by federal law, annual redeterminations of clinical eligibility will still be conducted under CHC. The CHC-MCO will transmit the information gathered using the interRAI™ HC tool during the needs reassessment to the IAE for the annual eligibility redetermination. The IAE will make the redetermination decision, subject to oversight by DHS. DHS monitors the CHC-MCOs to ensure that FED assessments are completed on a timely basis.

Community HealthChoices Transition

Q1. Will providers be given talking points so they can respond to consumer CHC questions?

- A. The Department of Human Services (DHS) is regularly disseminating information to providers and will inform providers when consumer notices are issued. There is also specific training targeted for service coordination entities and nursing facilities to assist in educating their participants.

For more information, please visit the CHC

website: <http://www.healthchoices.pa.gov/providers/about/community/index.htm>

Q2. Clarify that the pre-transition letters sent in July are only for those impacted in the 14 southwest counties?

- A. **Revised December 2, 2019.** This question pertains to the pre-transition letter that were set to potential CHC participants transitioning to CHC in the phase 1 southwest 14 counties. DHS sent pre-transition notices to these individuals in late September 2017.

Q3. Will everyone currently in the OLTL waivers be combined into one waiver? Does this mean that the OBRA waiver participants will be included in the combining process?

- A. The COMMCARE waiver ended 12/31/2017 and became the CHC waiver effective 1/1/2018. Aging waiver participants ages 60 and older, Attendant Care and Independence waiver participants ages 21 and older and OBRA waiver participants ages 21 and older who are nursing facility clinically eligible (NFCE) will transition to the CHC waiver. OBRA participants under 21 or not NFCE will remain in OBRA. Independence waiver participants under 21 will transition to the OBRA waiver. The Living Independence for the Elderly (LIFE) program will continue to be a choice for individuals residing in an area that offers the LIFE program.

For more information on waiver transitions, please refer to the Waiver Transitions Flowchart available here:

http://www.healthchoices.pa.gov/cs/groups/webcontent/documents/document/c_260104.pdf

Q4. When CHC starts, who develops the initial care plan for newly enrolled participants?

The CHC-MCO develops the initial person-centered service plan (PSCP) for newly enrolled participants. In developing a participant's PCSP, the CHC-MCO will use information gathered from the participant's Functional Eligibility Determination (FED), completed by the DHS' independent assessment entity (IAE), and data from the comprehensive needs assessment of the participant conducted by the CHC-MCO.

Q5. Will the participant enrollment process change under CHC for consumers?

- A. The participant enrollment process will be similar to how it was prior to CHC. Prior to CHC implementation, the Independent Enrollment Broker (IEB) provided choice counseling and enrollment assistance to participants to enable them to select a CHC-MCO and a primary care physician (PCP). After CHC implementation, the IEB continues to provide choice counseling and enrollment assistance to newly eligible participants and to individuals who contact the IEB directly or are referred to the IEB for assistance by third parties. The IEB is also responsible to assist enrolled participants who wish to change their CHC-MCO with plan transfers.

The IAE will conduct the initial level of care determinations using the FED tool. The FED generates a NFCE or nursing facility ineligible (NFI) determination.

The local County Assistance Office (CAO) will continue to determine financial eligibility for Medicaid.

Q6. When will people under the COMMCARE Waiver be moved into the Independence Waiver?

- A. All COMMCARE participants were transitioned to the Independence Waiver at the end of December 2017.

Q7. Revised March 20, 2018 – Question and response moved to Medicare section

Q8. If a nursing facility chooses not to be a CHC provider, do CHC residents have to go to a CHC participating facility?

- A. If a CHC participant is a resident of a nursing facility (NF) on the date CHC is implemented in the CHC zone, the participant will be permitted to continue receiving care at that NF until the participant either leaves the facility or is disenrolled from CHC, or the facility is no longer a Medical Assistance enrolled NF provider.

If a CHC participant needs to be admitted to a NF after CHC is implemented in a CHC zone, the participant must receive NF services from a NF that participates in the participant's CHC-MCO's provider network. If the NF subsequently leaves or is terminated from the network, the participant may continue to receive NF services from the NF for up to 60 days from the latter of the date the participant is notified by the CHC-MCO of the NF's termination or pending termination; or the date of the NF's termination, so long as the participant remains eligible for NF services. An exception to this continuity-of-care requirement is if the facility is being terminated for cause as described in 40 P.S. § 991.2117(b).

Q9. If a person is eligible to receive services through the Office of Developmental Programs (ODP), but they do not receive any ODP services, are they required to enroll in CHC?

- A. Individuals with an intellectual or developmental disability, including autism, who are receiving services beyond supports coordination through a program administered by the DHS Office of Developmental Programs, will not be enrolled in CHC unless they are NFCE and choose to enroll in CHC.

Q10. Revised March 20, 2018 – Question and response moved to Medicare section

Q11. How will the participant choose a CHC-MCO?

- A. During the pre-transition period, the IEB will contact potential participants to offer them information about CHC, the CHC-MCOs, and assist the individual with choosing a CHC-MCO. If an individual does not select a CHC-MCO, the IEB will assign the individual to a CHC-MCO according to criteria described in Exhibit J of the CHC Agreement. If a participant does not choose a CHC-MCO before transition occurs, the participant will be assigned to a CHC-MCO by the automatic assignment process described in DHS' Client Information System (CIS). Participants who are assigned to a CHC-MCO by the IEB or through the CIS auto-assignment process may select a different CHC-MCO at any time. The IEB will assist participants in choosing and transferring to a different CHC-MCO. For more detailed information related to assignment process and criteria, please refer to Exhibit J of the CHC Agreement.

After the CHC transition date, long-term services and supports (LTSS) participants will have the opportunity to make an advanced plan selection before being assigned by the IEB using the hierarchy or auto-assigned in CIS. Participants who are NFI Duals will be auto-assigned.

Q12. How does CHC impact the LIFE Program?

- A. The LIFE program will continue to be a choice for individuals residing in an area that offers the LIFE program. Individuals who already participate in the LIFE program can remain in their LIFE program and will not be moved into CHC unless they specifically ask to change. CHC participants who would prefer to participate in a LIFE program and qualify to participate in LIFE will be free to do so.

Q13. How will provider information be given to participants? Will each CHC-MCO have a provider database for a consumer to view online?

- A. The CHC-MCO must provide the IEB with an updated electronic version of its Provider Directory at a minimum on a weekly basis. The IEB will post this information on the IEB's website and use it in helping participants to select a CHC-MCO. In addition, the CHC-MCOs must have a web-based Provider Directory available in a machine-readable file and format as specified in 42 C.F.R. § 438.10. The CHC-MCO must also provide a hard copy of its Provider Directory if requested by a participant.

Q14. What can providers do to assist participants during the transition to CHC?

- A. Providers should encourage participants to participate in the CHC Third Thursday webinars to learn more about CHC and encourage them to participate in stakeholder engagements. Providers should ask participants to read any CHC-related information provided by DHS and encourage them to participate in educational sessions. Providers should also encourage participants to select a CHC-MCO by the date identified by DHS. Providers may also encourage participants to subscribe to the CHC listserv: <http://listserv.dpw.state.pa.us/olml-community-healthchoices.html>.

Participants may also view participant-specific trainings which are available at: <http://www.healthchoices.pa.gov/info/about/community/commpart/index.htm>

Q15. When will the provider receive a service authorization from the CHC-MCO for services that begin on or after the CHC implementation date?

- A. CHC-MCOs will issue service authorizations prior to the date CHC is implemented in each zone for services provided after each implementation date using data provided by DHS' Office of Long-Term Living. DHS will forward any requests for service authorizations that are pending as of December 31 prior to each implementation date to the CHC-MCOs for review and disposition. The CHC-MCOs will review these requests and provide authorization as appropriate. Service authorization requests occurring after December 31 prior to each implementation date should be directed to the participant's CHC-MCO, as indicated in the Eligibility Verification System (EVS).

Q16. Will authorizations be required for residents that are in a nursing facility before the CHC implementation date?

- A. Service authorizations will not be required prior to each January 1 implementation date, but NFs should contact the CHC-MCO to learn what is required for services provided after the January 1 implementation dates.

Q17. What happens if a nursing facility resident moves from HealthChoices (HC) to CHC?

- A. Implementation of CHC resulted in a change to the historic coverage requirements for NF services by the physical health (PH)-MCOs. In the HC zones where CHC is implemented, MA beneficiaries in PH-MCOs who enter nursing facilities are no longer disenrolled from their PH-MCO after receiving 30 days of continuous NF services. Beneficiaries receiving NF services in a CHC zone will remain open in their PH-MCO until they have been determined eligible for MA funded LTSS, and enrollment in a CHC-MCO is indicated in EVS. The CHC-MCO will begin to pay the day after the eligibility determination and is indicated by a CHC-MCO start date in EVS. For additional information, see MA Bulletin 03-18-20, Changes to Managed Care Coverage of Nursing Facility Services, which is available at: https://www.dhs.pa.gov/docs/Publications/Documents/FORMS%20AND%20PUBS%20MAP/c_283001.pdf

Q18. How will participants who currently receive Aging waiver services be impacted?

- A. Aging waiver participants who are NFCE will be enrolled in CHC and receive their home and community-based waiver services under CHC once CHC is implemented in their zone.

Q19. How are OBRA participants with an Intermediate Care Facility for Other Related Conditions (ICF/ORC level) of care impacted?

- A. The OBRA waiver will continue to operate statewide and serve participants who require an ICF/ORC level of care. Current OBRA waiver participants who have an ICF/ORC level of care will remain in the OBRA waiver and will not transition to CHC. In addition, the OBRA waiver will also serve participants, ages 18 through 20.

Q20. What happens to Medical Assistance NF residents who are not dual eligible?

- A. Medical Assistance NF residents who are not dual eligible will be enrolled in CHC if they are 21 years old or older.

Q21. To what extent are consumers and providers involved in providing input on materials before they are distributed?

- A. DHS is committed to stakeholder engagement throughout the implementation and ongoing operation of CHC. As part of this commitment, DHS is sharing consumer and provider communication materials for input. Consumer materials are shared with the Managed Long-Term Services and Support (MLTSS) Subcommittee of the Medical Assistance Advisory Committee (Sub MAAC) and provider materials are shared with provider associations. The Sub MAAC and provider associations provide input to DHS on behalf of their various constituents.

DHS is also committed to ensuring participants have involvement at the CHC-MCO level. The CHC-MCOs are required to establish and maintain several opportunities for participant input including a Participant Advisory Committee (PAC), Health Education Advisory (HEA) Committee, and a Pharmacy & Therapeutics (P&T) Committee.

The CHC-MCOs are required to establish and maintain a PAC for each zone in which they operate that includes participants, network providers and direct care worker representatives. The PAC advises the CHC-MCOs and DHS on the experiences and needs of participants.

The HEA Committee includes participants and providers in the community to provide input on the health education needs of participants.

The P&T Committee includes physicians, including a minimum of two behavioral health physicians, pharmacists, Medical Assistance program participants and other appropriate clinicians to provide input on the CHC-MCOs formulary – a DHS approved list of outpatient drugs.

Q22. Awareness flyers were scheduled to go out in August 2017 and pre-transition packets are to be sent in September 2017. For newly eligible consumers who are approved in August or September, will they receive this information in their first eligibility/approval notice, or will they get it as a separate mailing?

- A. **Revised December 2, 2019.** This question pertains to the notices that were sent to potential CHC participants transitioning to CHC in the phase 1 southwest 14 counties.

Q23. What packets will individuals receive who will be enrolled in CHC?

- A. Individuals who are receiving LTSS and individuals who are identified as dual eligible who will be transitioning to CHC at implementation will receive a pre-transition notice from the Department of Human Services. Individuals will then receive a pre-enrollment packet from the IEB. Finally, the IEB will send out a post-enrollment packet. Individuals will also receive a letter prior to transition announcing informational meetings and dates. Individuals who are found newly eligible for Medical Assistance (MA) will receive two notices. An MA notice of eligibility and a separate CHC pre-transition notice.

For more information, please visit the CHC website:

<http://www.healthchoices.pa.gov/info/about/community/commpart/index.htm>

Q24. Revised March 20, 2018 – Question and response moved to Medicare section

Q25. Does choosing a CHC-MCO for waiver services impact a CHC participant's health provider choices?

- A. A participant should consider both LTSS and PH providers when choosing their CHC-MCO. After the applicable continuity-of-care period, participants will receive their physical health and LTSS services from providers in the CHC-MCO's provider network.

Q26. If an individual is currently receiving Medical Assistance nursing facility services or home and community-based services under an Office of Long-Term Living waiver, does either the individual or provider need to complete another MA-51?

- A. No, the MA-51 information for current MA recipients will be maintained once they are enrolled in CHC.

Q27. Revised March 20, 2018 – Question and response moved to Medicare section

Q28. What happens if a LTSS participant who resides in a NF is originally from a county that is not in the same phase of CHC implementation as the NF?

- A. The LTSS participant's enrollment in CHC will be determined based upon the location of the NF.

Questions Added on December 2, 2019

Q29. Will the CHC-MCOs help new clients choose who will provide their care?

- A. While the CHC-MCOs are not permitted to assist participants in the selection of their providers, the CHC-MCOs offer a provider directory to participants which includes information to help the participant choose a provider.

Complaints and Grievances

Q1. What is a participant's recourse if the CHC-MCO reduces his or her services?

- A. If a CHC-MCO reduces a participant's services, the participant may file a grievance with the CHC MCO. If the participant needs help filing a complaint or grievance, a staff member of the CHC MCO will help the participant. The staff person can also represent the participant during the complaint or grievance process. The participant does not have to pay for the help of a staff member. This staff member will not have been involved in any decision about the participant's complaint or grievance.

The participant may also have a family member, friend, lawyer or other person help them file their complaint or grievance. This person can also help the participant if they decide they want to appear at the complaint or grievance review. For legal assistance the participant can contact their local legal aid office at 1-800-322-7572, visit (www.palegalaid.net) or call the Pennsylvania Health Law Project at 1-800-274-3258 (www.phlp.org).

All CHC services must be medically necessary and long-term services and supports must be identified in the standardized needs assessment and specified in the participant's Person- Centered Service Plan.

Q2. How can a participant get help if they want to file a complaint or grievance about their CHC-MCO?

- A. If a participant needs help filing a complaint or grievance, a staff member of the CHC-MCO will help the participant. The staff person can also represent the participant during the complaint or grievance process. The participant does not have to pay for the help of a staff member. This staff member will not have been involved in any decision about the participant's complaint or grievance.

Please refer to Q1 above for additional assistance that is available to a participant who needs help filing a complaint or grievance about their CHC-MCO.

Q3. Do services continue during the complaint and grievance process? If a consumer receives services during the complaint and grievance process, is the consumer responsible for payment if their complaint or grievance is not upheld?

- A. If a participant is currently receiving a service and they submit their complaint or grievance within the required timeframe, the service will continue at the previously authorized level until the complaint or grievance is decided. The required timeframes can be found on the notice the participant receives from the CHC-MCO and in the Participant Handbook, Section 8 Complaints and Grievances.

The CHC-MCO, not the participant, is financially responsible until the complaint or grievance is resolved as long as the participant submitted their complaint or grievance within the required timeframe.

Q4. If a consumer wants to appeal their level of care determination, who do they appeal to?

- A. Participants will receive a notice of determination and right to appeal. The appeal information includes instructions on how to submit an appeal request with the Department of Human Services.

Q5. Will a complaint and grievance procedure be available for CHC participants?

- A. The complaint and grievance process is contained in Section 8 of the Participant Handbook.

Continuity of Care

Q1. Can the CHC-MCOs extend the Waiver long-term services and supports (LTSS) continuity of care period beyond 180 days and what will be the determinant as to why this period is extended?

- A. This topic can be discussed with the CHC-MCOs. Following the 180-day period, the CHC-MCO may adjust its provider network in accordance with the network access and adequacy standards outlined in the CHC Agreement. The CHC-MCOs will likely seek to use contracted providers who can help meet the goals of improved coordination of care and improving the quality of services. However, in accordance with MA Bulletin 99-03-13, the CHC-MCO may extend the continuity of care when clinically appropriate.

Q2. How will the CHC-MCOs select providers after the continuity of care period? Will they require additional credentialing criteria? And when will they begin the process?

- A. This topic should be discussed with the CHC-MCOs. The CHC-MCOs will establish their own credentialing process and may impose additional credentialing criteria. The CHC-MCOs will likely seek providers who help to meet the goals of improved coordination of care and improving the quality of services.

Q3. Is there a requirement for all CHC-MCOs to contract with willing providers for the first six months? How does the "after the continuity of care" period impact the home and community-based (HCBS) and service coordinator providers?

- A. CHC-MCOs are required to contract with all willing and qualified existing LTSS providers of all types for 180 days after CHC implementation. Participants may keep their existing HCBS providers, including service coordinators, for the 180-day continuity of care period after CHC implementation. Following the 180-day period, the CHC-MCO may adjust its provider network in accordance with the network access and adequacy standards outlined in the CHC Agreement.

Q4. When arranging a contract with a CHC-MCO, define what is willing and qualified provider?

- A. A willing LTSS provider is a provider that is willing to contract with the CHC-MCO to provide services for a payment rate that is agreed upon by the provider and the CHC-MCO. A qualified provider is a provider that meets applicable Medical Assistance program participation or waiver requirements for the provider's provider type. This requirement will remain in effect for LTSS providers for 180 days after the CHC zone start date. Following the 180-day period, the CHC-MCO may adjust its provider network in accordance with the network access and adequacy standards outlined in the CHC Agreement.

Q5. In the earlier PowerPoint it states, "DHS is requiring an extended continuity of care period for nursing facilities." What is the extended time frame?

- A. Nursing facility (NF) residents' who reside in a NF located in the CHC zone on the implementation date, the continuity of care period extends until the resident's NF stay ends, the resident is disenrolled from CHC, or the NF is no longer enrolled in Medicaid.

Q6. How will participants be distributed among providers after the 180 days?

- A. The participants will have the opportunity to select the CHC-MCO plan that meets their needs. If participants do not select a plan, they will either be assigned to a CHC-MCO plan by the IEB, based on criteria established by the Department of Human Services (DHS), or they will be auto-assigned to a plan by DHS. DHS encourages all participants to select their plans. Once participants are enrolled in a CHC-MCO, they can choose their providers from the plan's provider network.

Q7. How will the CHC-MCOs handle Nursing Home Transition (NHT) after the continuity of care period?

- A. CHC-MCOs must provide NHT activities to participants residing in nursing facilities who express a desire to move back to their homes or other community-based settings. The CHC-MCO must provide NHT activities using appropriately qualified staff, whether employed by or under contract with the CHC-MCO. This topic should be discussed with the CHC-MCOs to learn about their plans after the continuity of care period.

Q8. Revised March 20, 2018 – Question and response moved to Medicare section

Q9. If the CHC-MCO does not contract with the service coordination entity or home care agency, how is a participant notified that the service coordination entity or home care agency is being dropped?

- A. Participants who transition into CHC at the start date for the CHC zone will have a 180-day continuity-of-care period for their service coordinator and home care agency. This means that the CHC-MCOs are required to continue services through all existing providers, including service coordination entities, for 180 days.

After the 180-day continuity of care period, the CHC-MCOs must notify participants if their service coordination entity will not be subcontracted with the CHC-MCO or if their home care agency is not part of the CHC-MCO's provider network.

Q10. Will the continuity of care be the same for those transitioning from OPTIONS or ACT 150 as it will be for those transitioning from OLTL waivers?

- A. **Revised May 1, 2018** – Assuming the individual remains eligible for the state-funded OPTIONS or ACT 150 program, participants who transition into CHC at the start date for the CHC zone, will continue to receive their services through OPTIONS or ACT 150. The CHC-MCOs must coordinate the participant’s transition into CHC with their Care Manager/Service Coordinator. For participants who are not eligible for long-term services and supports through CHC, the CHC- MCO is primarily responsible for any physical health services the participant may need.

In addition, as permitted by Section V.A.4 of the CHC Agreement, Expanded Services and Value-Added Service, the CHC-MCO may offer participants expanded or value-added services. If offered, the CHC-MCO may feature such services in approved outreach materials. Adding or changing value-added services requires modification of written materials and is subject to approval from the Department.

For more information, please visit <https://www.enrollchc.com/>. Click on “Choose” then “Compare Plans” to compare CHC Health Plan information.

Q11. During the 180-day continuity of care period, are providers required to contact both the SCE & CHC-MCO?

- A. During the 180-day continuity of care period, providers should contact and communicate with the CHC-MCOs. Communication with the service coordination entities is not required unless directed to do so by the CHC-MCOs. Providers should discuss this with the CHC-MCOs.

Q12. If a Person-Centered Service Plan (PCSP) is due after the 180-day period, can the service coordinator (SC) work with the participant to review a PCSP before it is expired?

- A. If the SC completes a new PCSP that results in a change to the services, the CHC-MCO must comply with the requirement that (1) the MCO must continue all existing HCBS waiver services through existing service providers including the SC for 180 days or (2) until a comprehensive needs assessment has been completed, a PCSP has been developed and implemented, whichever date is later. If the comprehensive needs assessment results in increased services, the new PCSP should be implemented and the CHC-MCO must allow the services to be provided by all existing HCBS waiver providers including the SC for the remainder of the 180-day period.

Q13. If at the end of the 180-day continuity of care period a service coordination entity does not renew with a CHC-MCO, can the consumer switch CHC-MCOs to allow continuity of care?

- A. If a participant chooses to transfer to a different CHC-MCO, service coordination will not be covered under the standard 60-day continuity of care period, since service coordination will be viewed as an administrative function of the CHC-MCO.

Q14. If at the end of the 180-day continuity of care period an in-home provider does not renew with a CHC-MCO, can the consumer switch CHC-MCOs to allow continuity of care?

- A. If a participant chooses to transfer to a different CHC-MCO during the initial 180-day continuity of care period, the receiving CHC-MCO must continue to provide the previously authorized services for 1) the greater of 60 days or the remainder of the 180 days, or 2) until a comprehensive needs assessment has been completed and a Person-Centered Service Plan (PCSP) has been developed and implemented, whichever date is later.

If a participant chooses to transfer to a different CHC-MCO after the initial 180-day continuity of care period, the receiving CHC-MCO must continue to provide the previously authorized services for 60 days or until a comprehensive needs assessment has been completed and a PCSP has been developed and implemented, whichever date is later.

Q15. Will hospice care or transitions be affected and how?

- A. 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.

Q16. What is the process and timeframes for a participant to select a new personal assistance services provider and service coordination entity if the participant's providers are no longer under contract with, or part of the CHC-MCOs network after the initial continuity of care period?

- A. Participants will receive at least 45 days advance notice from the CHC-MCOs and will have the opportunity to select a new Personal Assistance Services (PAS) provider in the CHC-MCOs provider network. CHC-MCOs will also notify participants whether their service coordinator will continue to provide service coordination. The CHC-MCO must offer the participants a choice of service coordinators from amongst those employed by or under contract with the CHC-MCO. Reference Exhibit V of the CHC Agreement for more detail.

Q17. After the end of a HCBS waiver participant's continuity of care period, when does the newly selected provider receive a service authorization?

- A. The newly selected provider will receive an updated service authorization after the completion of the comprehensive needs assessment.

Q18. Can a CHC-MCO end a service coordination contract before the end of the 180-day continuity of care period for bad performance?

- A. Yes, CHC-MCOs may terminate a provider for cause during the continuity of care period, as consistent with 40 P.S. § 991.2117(b).

Q19. Why is there a continuity of care period for NF residents when NF residents can stay as long as they want?

- A. CHC participants who reside in a NF when CHC is implemented in the CHC zone will be permitted to continue receiving care at that facility until the participant either leaves the facility or is disenrolled from CHC, or the facility is no longer enrolled as a provider in the MA program.

Participants admitted to a NF after the CHC implementation date will receive the standard 60-day continuity of care protections.

Q20. If a long-term resident of the nursing facility prior to 1/1/18 exceeds their 15-day bed hold, but is still expected to return to the facility, will their continuity of care be interrupted?

- A. As long as the participant remains a resident of the NF, a temporary hospitalization will not interfere with or terminate the continuity of care period even if it exceeds the 15-day bed hold period.

Q21. Is there a provision if a hospital or primary care physician is not contracted with a specific CHC-MCO in the NF coverage area?

- A. 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.

Q22. Who is considered a NF resident for the purposes of the continuity of care period?

- A. **Revised January 26, 2018** – A person who was admitted as a resident to and, as of the CHC implementation date, was receiving NF services from a general, county, special rehabilitation or hospital-based NF which is licensed by the Pennsylvania Department of Health (DOH) and enrolled in the Pennsylvania Medical Assistance Program.

Questions Added on Month Date, 2019

Q23. Can participants change CHC-MCO's during continuity of care?

- A. Yes, participants may switch CHC-MCOs at any time, including during the continuity of care period. Please refer to Q17 in the General CHC Participant Related section of this document for more information.

Q24. What happens when a participant hasn't selected a CHC-MCO by 2/1/2020? Do providers continue to bill through PROMISe™ during the 180 days?

- A. No, providers should bill the CHC-MCO for services provided on and after the CHC implementation date. If participants do not select a plan, they will either be assigned to a CHC-MCO plan by the IEB, based on criteria established by DHS, or they will be auto-assigned to a plan by DHS. Please refer to Q11 in the Community HealthChoices Transitions and Q1 in the Participant Enrollment sections of this document for more information.

Electronic Visit Verification System (EVV)

Q1. Will EVV be required in CHC?

- A. The 21st Century Cures Act requires states to implement EVV for personal care services by January 1, 2020, and home health care services by January 1, 2023 (Sec. 207). In CHC, EVV will be required for personal assistance services, respite, and participant-directed community supports by January 1, 2020.

Q2. What will the EVV impact be on participants, CHC-Managed Care Organizations (MCO) and the Financial Management Services (FMS) Vendor?

- A. **Revised December 2, 2019** – CHC-MCOs are required to have EVV systems that comply with the 21st Century Cures Act and EVV will be required for personal care services by January 1, 2020 and home health care services by January 1, 2023. The Department of Human Services (DHS) is currently working with DXC, DHS' Medicaid and Management Information System (MMIS) vendor, and Sandata, DXC's subcontractor for EVV services, to develop an EVV system that will integrate with DHS' existing Medicaid Management Information System (MMIS), PROMISE. DHS is developing the state EVV system with a soft launch that began in October 2019. DHS will send out regular updates on the progress of the implementation and will reach out to provider agencies with surveys, informational updates, and stakeholder briefings throughout the implementation process. While DHS will offer the DHS EVV system to providers doing business in FFS, Pennsylvania is using an open EVV system model. Providers may use their own EVV vendor/system so long as their system captures the six items required under the Cures Act and can interface with the DHS Aggregator.

Providers serving participants who are already enrolled in one of the CHC-MCOs will have the option to have their own system or use the CHC-MCO's EVV system, HHAExchange. A CHC-participating provider with their own internal EVV system must work with each contracted CHC-MCO to ensure the provider's system is able to send information to HHAExchange. Providers should begin discussing training and system options with their contracted CHC-MCO(s) in order to implement EVV by January 2020.

For participant-directed programs, the vendor fiscal agent, Public Partnerships, LLC (PPL), is utilizing their EVV system, Time4Care, to satisfy EVV requirements.

More information on EVV can be found at <https://www.dhs.pa.gov/providers/Billing-Info/Pages/EVV.aspx>

For further questions regarding EVV, please email RA-PWEVVNotice@pa.gov.

Q3. Will patient signatures be required at the end of every visit if the agency is using EVV?

- A. If a service requires a signature prior to the implementation of EVV, then the service will still require a signature or voice capture to verify the services received once EVV is implemented. For example, consumer-directed services require a signature to verify the services. A signature will be required for these service visits once EVV is implemented.

Q4. Some CHC participants do not have a home phone. Will a home phone be required for EVV?

- A. **Revised January 17, 2018** – EVV does not require individuals/members to have a landline home phone. If a participant does not have a landline home phone or does not want their personal attendant to use this phone, attendants may use smartphones or tablets to clock in and out.

Questions Added on December 2, 2019

Q5. How do we integrate our EVV information?

- A. A CHC-participating provider with their own internal EVV system must work with each contracted CHC-MCO to ensure the provider’s system is able to send information to HHAExchange. Providers in CHC will send their data to the CHC-MCOs who will do claims comparisons. The CHC-MCO will then send the EVV data to the DHS aggregator. Providers should begin discussing training and system options with their contracted CHC-MCO(s) in order to implement EVV for Personal Care Services by January 2020. If providers are transitioning to CHC on January 1, 2020, providers should begin reaching out to the CHC-MCOs to identify EVV options and training opportunities during the fall of 2019 in order to begin using EVV on January 1, 2020.

Q6. What information must be collected and verified through EVV?

- A. The 21st Century Cures Act requires that the EVV system collect and verify the following six elements: the type of service provided, the individual receiving the service, the individual providing the service, the date the service was provided, the location of the service delivery and the time the service begins and ends. In addition to these core elements, EVV systems must be able to meet the technical specifications outlined by DHS.

More information on EVV can be found at: <https://www.dhs.pa.gov/providers/Billing-Info/Pages/EVV.aspx>

Q7. Will CHC-MCOs have any additional EVV requirements above and beyond what is required by the 21st Century Cures Act?

- A. According to the terms of the agreement, each CHC-MCO must comply with all applicable state and federal requirements. The CHC-MCOs can adopt additional requirements for network providers. Providers should discuss requirements with CHC-MCOs as part of the contracting process.

Q8. Are there any criteria for EVV from the CHC-MCOs? Example: What to do when caregiver does not sign in or cannot sign in?

- A. Providers should discuss additional CHC-MCO requirements with the CHC-MCOs as part of the contracting process. Providers must also develop policies and any necessary training to ensure their staff understand EVV procedures and expectations.

Q9. If providers choose to use the CHC-MCO's EVV system, HHAeXchange, will they be in compliance? Or do you anticipate that it may need to change?

- A. If the provider chooses the CHC-MCO's EVV system, HHAeXchange, they will be in full compliance; there is no need to change.

Q10. For soft EVV launch – if we are using another vendor, what effective date applies?

- A. Beginning in October 2019, DHS will expect provider agencies to use EVV for the capture and verification of PCS visits. The soft launch period between October and December 2019 will be a time for providers and clients to adapt to the use of EVV without impact to claims. During this soft launch, DHS and Sandata will be available to answer questions and concerns that may come up regarding EVV. Additionally, DHS will analyze usage data to determine which providers are not utilizing EVV adequately and will reach out to provide direct technical assistance.

More information on EVV can be found at: <https://www.dhs.pa.gov/providers/Billing-Info/Pages/EVV.aspx>

Q11. Is there a cost for providers to use the CHC-MCO's EVV system, HHAeXchange?

- A. Providers should contact the CHC-MCOs to discuss if there is a cost for providers to utilize their EVV system(s).

Q12. Will HHAeXchange interface w/PROMISE™?

- A. HHAeXchange, the CHC-MCO's EVV system, will be required to interface with the DHS Aggregator. The DHS Aggregator is a system that will integrate data from third-party systems which includes PROMISE™ and the DHS EVV system into a single uniform platform to facilitate payment of claims.

More information on EVV can be found at: <https://www.dhs.pa.gov/providers/Billing-Info/Pages/EVV.aspx>

Q13. If a provider chooses to have their own EVV system, do they have to pay to maintain the system? Do I have to buy phones for my employees?

- A. DHS will not charge providers for the use of the DHS EVV system. However, agency providers who choose to use an Alternate EVV system may be charged for that system. In addition, these providers will be responsible for working with DHS and its vendor, Sandata, to integrate with the DHS Aggregator and will be responsible for any interface costs charged by the provider's Alternate EVV vendors.

A smart device is only necessary if the caregiver uses the mobile application to capture the visit data; however, the use of the mobile application is optional and DHS does not prefer the use of the mobile application over telephony. For caregivers using the mobile application as part of the DHS EVV system, DHS has a bring your own device (BYOD) policy where employees may use their personal computing devices, such as smartphones and tablets, to download and access the mobile application. The mobile application called "Sandata Mobile Connect" is a free application that is available on IOS and Android operating systems.

More information on EVV can be found at: <https://www.dhs.pa.gov/providers/Billing-Info/Pages/EVV.aspx>

Q14. Can you use both a home phone and the DCW mobile app to clock in and out, or does it need to be one or the other?

- A. The DHS Sandata system allows for the use of both a home phone and mobile app interchangeably. However, since DHS is implementing an open system, this answer is dependent on the system being used. Certain systems have limitations on the ability to switch between devices.

Q15. What if a caregiver forgets to clock in and out? Will we run into issues if we manually check them in and out?

- A. Check-in and check-out times are required information that must be captured as part of the visit. In instances where the check-in and check-out times are unable to be captured through the mobile application or telephony, the times can be fixed through manual entry in the web portal.

Q16. What happens when EVV is not able to be used? For example, the landline is down, there is no landline, or the employee forgot to clock in or out. Will the provider be able to bill for the visit?

- A. Check-in and check-out times are required information that must be captured as part of the visit. In instances where the check-in and check-out times are unable to be captured through the mobile application or telephony, the times can be fixed through manual entry in the web portal. A CHC-participating provider utilizing their own internal EVV system or the CHC-MCO's EVV system should contact either their EVV vendor or the CHC-MCO to discuss these specific situations.

Eligibility Verification System (EVS)

Q1. How will providers know which CHC-MCO their existing consumer has selected?

- A. EVS will identify CHC participants and their CHC-MCO. EVS will display the CHC-MCO plan code information along with the participant's Primary Care Physician (PCP).

Q2. How is access to the EVS for verification of participants obtained?

- A. For more information related to EVS, refer to Provider Quick Tip #11 at:
[https://www.dhs.pa.gov/providers/Quick-Tips/Documents/11%20-%20The%20Eligibility%20Verification%20System%20\(EVS\).pdf](https://www.dhs.pa.gov/providers/Quick-Tips/Documents/11%20-%20The%20Eligibility%20Verification%20System%20(EVS).pdf)

Q3. What is EVS?

- A. The PROMISE™ EVS enables a provider to determine a Medical Assistance recipient's eligibility as well as their scope of coverage. For more information related to EVS, refer to Provider Quick Tip #11 at:

[https://www.dhs.pa.gov/providers/Quick-Tips/Documents/11%20-%20The%20Eligibility%20Verification%20System%20\(EVS\).pdf](https://www.dhs.pa.gov/providers/Quick-Tips/Documents/11%20-%20The%20Eligibility%20Verification%20System%20(EVS).pdf)

Q4. Will providers still be able to use the PROMISE™ EVS to verify participant eligibility for CHC?

- A. Yes, the EVS methods, inquiry and response formats will not change with the CHC implementation. EVS will identify CHC participants and their CHC-MCO. All other existing waiver benefit packages and HealthChoices managed care responses remain unchanged.

Q5. Will there be any training or webinars on EVS? Including Third Party Liability (TPL) Information?

- A. The EVS methods, inquiry and response formats will not change with the CHC implementation. EVS will include information of the participant's CHC-MCO along with any TPL information. For training information, providers should contact the PA Provider Assistance Center at 1-800-248-2152.

Q6. Will EVS be updated with the CHC-MCOs in accordance with the dating rules or as the participant changes CHC-MCOs?

- A. A participant has the right to change his or her CHC-MCO at any time; however, the participant's enrollment in the new plan will take effect depending on when the participant requests the transfer based upon eligibility system dating rules. Generally, if a participant requests to transfer to a new plan during the first half of the month, the participant's enrollment in the new plan will be effective on the first day of the following month. If the participant requests to transfer during the second half of the month, the participant's enrollment in the new plan will be effective on the first day of the second month following the transfer request. For example, if a participant makes a request to transfer to a new plan on March 2, 2018, the participant will be enrolled in the new plan effective April 1, 2018. If the participant makes the request on March 16, 2018, the participant will be enrolled in the new plan effective May 1, 2018.

The CHC-MCO is prohibited from restricting participants from changing CHC-MCOs. Service Coordinators and the Independent Enrollment Broker will assist participants in facilitating a seamless transition between CHC-MCOs.

EVS is updated daily to reflect the most recent eligibility. A recipient's eligibility is subject to change; therefore, you should use EVS to verify eligibility each time you provide services to recipients.

Questions Added on December 2, 2019

Q7. Is there an online portal to check EVS?

- A. Providers can submit individual web interactive EVS requests via the PROMISE™ Internet. Instructions on how to register and use the PROMISE™ Internet can be found in the PROMISE™ Internet User Manual.

For more information related to EVS, refer to Provider Quick Tip #11 at:

[https://www.dhs.pa.gov/providers/Quick-Tips/Documents/11%20-%20The%20Eligibility%20Verification%20System%20\(EVS\).pdf](https://www.dhs.pa.gov/providers/Quick-Tips/Documents/11%20-%20The%20Eligibility%20Verification%20System%20(EVS).pdf)

Q8. How often should we be checking a participant's eligibility? If we check EVS on the 1st of the month, will it show the CHC-MCO for the entire month? Or should we do 1st and 15th?

- A. EVS is updated daily to reflect the most recent eligibility. A participant's eligibility is subject to change; therefore, you should use EVS to verify eligibility each time you provide services to participants.

Q9. Is EVS the only place to check eligibility? Can we see this also in HHAeXchange portal?

- A. HHAeXchange is an EVV and billing option for providers who render homecare services for our MCO. HHAeXchange should not be used to verify eligibility. Providers should be using EVS to determine a participant's eligibility status.

Q10. How do we register for Batch EVS? And is there someone who can help us walk through Batch EVS setup?

- A. For more information related to EVS, refer to Provider Quick Tip #11 at:
[https://www.dhs.pa.gov/providers/Quick-Tips/Documents/11%20-%20The%20Eligibility%20Verification%20System%20\(EVS\).pdf](https://www.dhs.pa.gov/providers/Quick-Tips/Documents/11%20-%20The%20Eligibility%20Verification%20System%20(EVS).pdf)

For training information, providers should contact the PA Provider Assistance Center at 1-800-248-2152. Please also see EVS Q2 & Q5.

Q11. Is EVS information real time?

- A. EVS is updated daily to reflect the most recent eligibility. A recipient's eligibility is subject to change; therefore, you should use EVS to verify eligibility each time you provide services to participants. Please also see EVS Q6.

General CHC Related

Q1. Will each CHC-MCO have the same regulations for home-based services?

- A. According to the terms of the agreement, each CHC-MCO must comply with all applicable state and federal requirements. The CHC-MCOs can adopt additional requirements for network providers. Providers should discuss requirements with CHC-MCOs as part of the contracting process.

Q2. Will the Department of Health (DOH) have regulations on CHC-MCOs?

- A. According to the terms of the agreement, each CHC-MCO must comply with all applicable state and federal requirements. The CHC-MCOs can adopt additional requirements for network providers. Providers should discuss requirements with CHC-MCOs as part of the contracting process.

Q3. Will CHC-MCOs provide a list of all providers?

- A. Yes, the CHC-MCO must use a web-based provider directory. The CHC-MCO must notify its participants annually of their right to request and obtain a hard copy of the provider directory and where the online directory may be found. The Independent Enrollment Broker (IEB) will also have a master provider directory available on its website that lists all providers participating in the CHC-MCOs networks.

Q4. What happens when a participant is reassigned to another provider when their provider is terminated?

- A. CHC-MCOs have requirements to notify the Department of Human Services (DHS) and impacted participants when a provider is terminated from their provider networks. The CHC-MCOs are required to assist participants with selecting new providers and participants have continuity-of-care protections.

Q5. How will participants requesting long-term services and supports (LTSS) be tracked?

- A. A participant who has not been determined nursing facility clinically eligible (NFCE) and requests to be evaluated for LTSS will be referred to the IEB. The IEB will assist the participant with the LTSS application and eligibility process. The IEB will track the participant as he or she proceeds through the process. Once the participant is determined eligible for LTSS, the CHC-MCOs will conduct a comprehensive needs assessment to determine the participant's LTSS needs. If a participant is eligible for LTSS and chooses to receive services through the LIFE program, the LIFE program will conduct the assessment to determine LTSS needs.

Q6. Will the CHC-MCOs be working with the IEB?

- A. Yes, the CHC-MCOs are required to work with the IEB in many areas such as providing outreach materials, collaborating when a participant has unmet needs, service gaps, or a need for service coordination, identifying and communicating with individuals with limited English proficiency, coordinating enrollment information, and exchanging provider and participant data.

Q7. Will there be changes to the COMPASS website to support CHC?

- A. COMPASS is continuously updated to improve the application process for state benefits. Most recently, the mobile application myCOMPASS PA was launched to allow access to benefits from anywhere, at any time. Participants can review what they receive, check the status of submitted applications, upload documents, and report changes directly from a mobile phone.

Q8. Will DHS be able to handle the additional work with the IEB and other necessary tasks to support CHC while continuing to support the fee-for-service (FFS) program?

- A. The Governor and Secretaries of Human Services, Health and Aging are committed to the success of CHC and have looked to maximize the use of automation and leverage staff to support the implementation of CHC and the ongoing LTSS FFS operation.

Q9. Is January 1, 2018 remaining as the implementation date for the phase 1 of CHC?

- A. Yes, the southwest zone will be implemented January 1, 2018.

Q10. Will non-profit status be affected by working with and being paid by for profit CHC- MCOs?

- A. Providers should consult with their legal counsel to discuss any contracting-related concerns including those related to impacts on non-profit status.

Q11. What are consistent, accessible ways for consumers to be involved beyond the sub-MAAC on MLTSS?

- A. DHS is committed to stakeholder engagement throughout the implementation and ongoing operation of CHC. DHS will continue the Third Thursday webinars and MLTSS sub-MAAC.

DHS is also committed to ensuring participants have involvement at the CHC-MCO level. The CHC-MCOs are required to establish and maintain several opportunities for participant input including a Participant Advisory Committee (PAC), Health Education Advisory (HEA) Committee, and a Pharmacy & Therapeutics (P&T) Committee.

- The CHC-MCOs are required to establish and maintain a PAC for each zone in which it operates, to include participants, network providers and direct care worker representatives. The PAC advises the MCOs and DHS on the experiences and needs of participants.
- The HEA Committee includes participants and providers in the community to provide input on the health education needs of participants.
- The P&T Committee includes physicians and participants. The committee develops a list, which is approved by DHS, of outpatient drugs determined to have a significant, clinically meaningful therapeutic advantage over other outpatient drugs in the same class in terms of safety, effectiveness, and cost.

The CHC-MCO's participant handbook will advise participants how they can participate in CHC-MCO advisory committees.

Q12. What is the home and community-based services (HCBS) loan program? What can the loans be used for?

- A. The HCBS loan program is intended to support long-term care providers as they position themselves to successfully transition to CHC. The loans will support projects that help the commonwealth to improve the quality of care for seniors and people with disabilities by building infrastructure so individuals will have more choices available to them. More details on the program can be found at <https://www.dhs.pa.gov/providers/Providers/Pages/Long-Term-Care-Providers.aspx>.

Q13. Do providers have the right to suspend or deny service to a consumer based on policies (ex. Violent, illegal, seriously disruptive behavior) prior to due process of dismissing a participant?

- A. The CHC-MCOs must develop provider policies, which DHS must approve, including requests from providers to dismiss participants from the practice through an expedited process.

Q14. Can consumers submit verification of payment for a covered service and receive reimbursement?

- A. Network providers are required to submit claims for services provided to participants and not request reimbursement from the participants. In cases such as the use of a private vehicle for medical related transportation, the county Medical Assistance Transportation Program (MATP) may reimburse the costs of traveling to medical appointments when appropriate.

Q15. If a participant is Nursing Facility Ineligible (NFI) and not currently receiving LTSS, does the CHC-MCO receive a per person/per month capitated rate?

- A. The CHC-MCOs receive a monthly capitated payment for both NFI and NFCE individuals. The amounts differ based on the age, dual Medicare and Medicaid eligibility, and NFCE/NFI status.

Q16. Will MCOs be prohibited from being the CHC-MCO service coordinator (SC) and personal assistance services (PAS) provider to eliminate a conflict of interest? A few years ago it was determined to be a conflict of interest for a service coordination entity to also be the participant's service provider. What, if anything, will be put in place to ensure that CHC-MCOs don't create a provider agency?

- A. CHC-MCOs are required to provide service coordination as an administrative service and may provide service coordination with their staff or through a subcontract arrangement.

To avoid conflict concerns, DHS has established requirements for related parties. The CHC Agreement defines a related party as “An entity that is an Affiliate of the CHC-MCO or a CHC-MCO subcontractor and (1) performs some of the CHC- MCO or subcontracting CHC-MCO's management functions under contract or delegation; or (2) furnishes services to Participants under a written agreement; or (3) leases real property or sells materials to the CHC-MCO or subcontracting CHC-MCO's subcontractor at a cost of more than \$2,500.00 during any year of this Agreement.”

CHC-MCOs that have a hospital, nursing facility, or home health agency as a related party must negotiate with and make referrals in good faith to providers that are not related parties. The CHC-MCO must offer participants a choice of related-party and non-related party network providers. A hospital, nursing facility, or home health agency that is a related party to a CHC-MCO must negotiate in good faith with other CHC-MCOs regarding the provision of services to participants. DHS may terminate the agreement with the CHC-MCO if it determines that a provider related to the CHC-MCO has refused to negotiate in good faith with other CHC-MCOs.

Q17. Do the local County Assistance Office (CAO) and Area Agency on Aging (AAA) stay the same, just different names?

- A. The Department of Human Service's CAOs do not have any change in their function or their name. The CAOs still determine financial eligibility for MA programs, including CHC. Aging Well (a subsidiary of the Pennsylvania Association of Area Agencies on Aging (P4A), which represents all AAAs) may take on certain functions to support CHC. Some of these functions may have previously been performed by AAAs.

Q18. What is the term (length) of the agreement with CHC-MCOs and when will the next bidding be held for new CHC-MCO providers?

- A. The term of the Southwest Zone agreements commenced on 1/1/2018 and will have a five-year term.

The term of the Southeast Zone agreements commenced on 1/1/2019 and will have a four-year term.

The term of the Lehigh-Capital, Northwest, and Northeast Zone agreements will commence on 1/1/2020 and will have a three-year term.

DHS may, at its discretion, choose to extend the term of the agreements for one additional period of two years.

Q19. How can we access a CHC-MCO's agreement with the state?

- A. The Final CHC Agreement for the current year is available in the Supporting Documents section of the CHC website; however, the rate information is redacted.

CHC supporting documents can be found here:

<http://www.healthchoices.pa.gov/info/resources/publications/community/supporting-documents/index.htm>

Q20. Is the version of the CHC waivers that were submitted to the Centers for Medicare and Medicaid Services (CMS) publicly available?

- A. The approved CHC related waivers are available on the CHC website:

<http://www.healthchoices.pa.gov/info/resources/publications/community/supporting-documents/index.htm>

Q21. Will the three CHC-MCOs cover all of Pennsylvania or will certain ones be available only in certain areas?

- A. All three CHC-MCOs will cover all CHC zones throughout the state.

Q22. If a participant is currently enrolled in a HealthChoices plan that is not offered under CHC, does the participant need to change plans?

- A. A CHC participant must select one of the three CHC-MCOs. If a participant is enrolled in a HealthChoices PH-MCO that is not affiliated with one of the three selected CHC-MCOs, the CHC participant will need to select one of the three CHC-MCOs.

Q23. Will a participant be able to choose from among one of the three CHC-MCOs and pick a provider such as an attendant?

- A. Yes, a participant has the freedom to choose both the CHC-MCO and their service providers from the CHC-MCO's provider network. In addition, all CHC-MCOs must offer participants receiving home and community-based services the opportunity to self-direct PAS and employ their own PAS provider, who can be a family member, a friend, a neighbor, or any other qualified personal assistance worker as determined by the Department of Human Services.

Q24. Is PA Health and Wellness known by another name?

- A. PA Health & Wellness is a Managed Care Organization and subsidiary of Centene Corporation (Centene).

Q25. What's the difference between the state hotlines - 1-800-757-5042, 1-800-932-0939, 1-833-735-4416, and 1-833-735-4417?

- A. DHS has established a call center to specifically assist providers and participants with CHC. 1-833-735-4416 is the CHC Participant Call Center and 1-833-735-4417 is the CHC Provider Call Center. The Office of Long-Term Living (OLTL) also has call centers to assist participants and providers with fee-for-service questions. 1-800-757-5042 is the OLTL Participant Line and 1-800-932-0939 is the OLTL Provider Line.

Q26. How do you get on the list serve?

- A. A list serve has been established for ongoing updates on the CHC program. It is titled OLTL-COMMUNITY-HEALTHCHOICES. Please visit the ListServ Archives page at <http://listserv.dpw.state.pa.us> to update or register your email address.

Q27. Has OLTL approved the CHC-MCO contracts that are being presented to providers? Not all providers have the resources to pay for an independent review of each contract.

- A. DHS' agreement with the CHC-MCOs requires that the CHC-MCOs include certain provisions in their provider agreements and that the CHC-MCOs submit their provider contract agreements to OLTL for approval. OLTL's review, which only focuses on whether the provider agreements include the required content, is not a substitute for the provider's own review. Providers should consult with their own legal counsel regarding any contracting questions or concerns.

Q28. What guidance/ instruction will be given to the CHC-MCO from the DHS?

- A. The CHC Agreement establishes requirements, which the CHC-MCOs must meet. DHS has provided technical assistance on various topics such as housing, HCBS and reimbursement, service coordination, nursing facility services and reimbursement, third party liability, information technology systems, and behavioral health. DHS is also providing written documentation on various programmatic topics.

Q29. What is the OLTL's role under the new CHC-MCO arrangement?

- A. Under CHC, OLTL will be responsible for the administration of CHC and will have full, ongoing oversight and monitoring functions of the CHC-MCOs. OLTL will review and approve processes, policies, manuals, and procedures of each CHC-MCO.

Q30. Will the current bed transfer process continue under CHC?

- A. In accordance with state and federal regulations, the DHS and the CHC-MCOs must ensure participants have adequate access to nursing facility services. DHS will continue to monitor access and will continue the bed request and bed transfer request processes in accordance with 55 Pa. Code Chapter 1187 subchapter L unless other regulations related to this process are promulgated.

Q31. Will reimbursement be backed by the state if the CHC-MCO is failing to make payment?

- A. DHS will not make payments directly to providers once CHC is implemented in a CHC zone. However, DHS has established several mechanisms to help ensure providers receive timely payments from CHC-MCOs, including requirements to ensure CHC-MCOs' financial viability and readiness to pay claims, and claims processing timeliness.

CHC-MCOs are required to meet equity and solvency requirements and other financial protections to ensure they have the financial resources to pay providers.

The CHC-MCOs must demonstrate during readiness review that they have the ability to provide services as required by the agreement prior to implementation of CHC in a given zone. This includes demonstrating their claims processing system.

If DHS determines that a CHC-MCO has not complied with the claims processing timeliness standards, DHS may impose sanctions on the CHC-MCO.

Q32. Why does DHS' Quality Strategy not include a CHC Ombudsman?

- A. The Medicaid Managed Care Rule requires DHS to have a Beneficiary Support System in all of its managed care programs including CHC. The Department is including all tasks related to Beneficiary Support System in the Enrollment Services Request for Application anticipated to be released in early 2020. These tasks include activities that are typically performed by an Ombudsman.

Q33. How is DHS reaching consumers who are not online or have Limited English Proficiency (LEP)?

- A. In an effort to relay information through various formats, DHS is mailing information about CHC to all individuals impacted by CHC, working with stakeholders to help relay information about CHC, and holding in-person meetings. CHC-MCOs must mail notices to participants and provide hard copies of important documents, including its provider directory, to participants upon request.

DHS is taking steps to provide meaningful access for individuals with LEP.

DHS is sending information to consumers by mail which will include tag lines. CHC-MCOs must include tag lines in the top 15 prevalent languages in Pennsylvania, in addition to an English tag line in large print, on all significant publications and communications. CHC-MCOs must also provide oral interpretation in all languages and written translations in prevalent languages determined by DHS. CHC-MCOs must revise and update their policies, procedures, and materials to integrate templates and taglines in accordance with the requirements.

Q34. Are the certain zip codes in the HEZ (health enterprise zone) involved in the CHC program?

- A. Yes, when CHC is implemented in the southeast zone effective January 1, 2019 all participants residing in a zip code covered by the HEZ will be enrolled in CHC. The goals of CHC and HEZ are consistent – improving coordination of services, achieving better health outcomes, and developing a more sustainable system.

Q35. Will the CHC-MCOs have a local office in each region?

- A. The CHC-MCO must have an administrative office within each CHC zone. In its discretion, DHS may grant exceptions if the CHC-MCO has administrative offices located elsewhere in Pennsylvania and the CHC-MCO is in compliance with all standards set forth by the Pennsylvania DOH and Pennsylvania Insurance Department (PID).

Questions Added on December 8, 2017

Q36. How will services be coordinated for sign language interpreters or captioning services for people who are hard of hearing?

- A. The CHC-MCO must provide alternative methods of communication for participants who have neurocognitive impairments or who are visually or hearing impaired or both, including Braille, audio tapes, large print, compact disc, DVD, computer diskette, special support services, and electronic communication. The CHC-MCO must, upon request from the participant, make all written materials disseminated to Participants accessible to visually impaired participants at no cost to the participant. The CHC-MCO must provide TTY and/or Pennsylvania Telecommunication Relay Service for communicating with participants who are deaf or hearing impaired, upon request.

The CHC-MCO must include appropriate instructions in all materials about how to access or receive assistance to access materials in an alternative format. The CHC-MCO must include, in all written material taglines as well as large print, explaining the availability of written translation or oral interpretation to understand the information provided and the toll-free and TTY/TDD telephone number of the CHC-MCO's call center. Large print means printed in a font size no smaller than eighteen (18) points.

Q37. How will the CHC-MCOs handle requests for reasonable accommodations or an interpreter for a person who speaks another language?

- A. CHC-MCOs are expected to comply with federal laws and regulations by providing for translation services and other accommodations to meet the needs of those participants for whom English is not their primary language and for those who are blind and/or deaf.

Q38. Will the CHC-MCOs collaborate or partner with the existing county offices, e.g. Area Agency on Aging, Mental Health/Intellectual Disability, housing, food programs, etc.?

- A. The CHC-MCOs must collaborate and partner with county agencies and offices that administer programs or provide resources needed to meet a participant's assessed needs.

Q39. Can the current SC procedures be made less complicated and confusing?

- A. One of the objectives of CHC is to improve the coordination of care for participants. Under CHC, the SC will coordinate Medicare, LTSS, physical health services and behavioral health services. The SC will also assist in accessing, locating and coordinating needed covered services and non-covered services such as social, housing, educational and other services and supports.

Q40. If an individual is admitted to a skilled nursing facility, and the discharge plan is to return home, can the individual remain in the nursing facility even if he or she is not nursing facility clinically eligible?

- A. To receive Medicaid funded long-term services and supports under CHC, a participant must be NFCE. An individual who is not NFCE is considered NFI and cannot receive LTSS under CHC.

Q41. What CHC services are being planned for older individuals who do not need nursing facility level of care, but are residing in a personal care facility or an assisted living facility?

- A. Current residents of personal care homes (PCHs) who are receiving HCBS may continue to receive services in that setting. NFI duals participants, who are living in PCHs, can also remain in their PCHs and receive physical health services under CHC. Once they need LTSS, these participants must transition to another living arrangement to receive HCBS, unless they are receiving residential habilitation services in a setting compliant with 42 C.F.R. § 441.301(c)(4) and (5).

Q42. How will the gap be filled from nursing facility if community-based services are not adequate to meet elder's needs?

- A. CHC-MCOs are responsible for coordinating the long-term support and service needs of their participants. For individuals requiring LTSS, the CHC-MCO must have a written holistic person-centered service plan that identifies and addresses how LTSS will be provided and coordinated. The CHC-MCO must ensure that their provider network is adequate to meet the needs of their participants.

Q43. Why are personal care facilities not a CHC option?

- A. Current residents of PCHs who are receiving HCBS may continue to receive services in that setting. NFI duals participants, who are living in PCHs, can also remain in their PCHs and receive physical health services under CHC. Once they need LTSS, these participants must transition to another living arrangement to receive HCBS, unless they are receiving residential habilitation services in a setting compliant with 42 C.F.R. § 441.301(c)(4) and (5).

Q44. Is DHS planning to use a statewide Health Information Exchange (HIE) to share information since a participant may have an integrated Person-Centered Service Plan (PCSP), e.g. LTSS PCSP, physical health care plan, behavioral health case management plan, dual eligible special needs plan (D-SNP) care plan, etc.

- A. Currently, the Department is not mandating an HIE for CHC however, the CHC-MCOs are encouraged to participate in other Department activities related to HIE such as through the physical HealthChoices program or through their own exchange.

Q45. Will nursing facilities continue to counsel and refer directly to Nursing Home Transition (NHT) providers or will the process move to the CHC-MCOs?

- A. Nursing facilities will counsel their residents and make referrals for NHT services to the CHC-MCO and SC chosen by the resident.

Q46. What impact does DHS expect CHC to have on NHT? And what steps are being taken to support NHT?

- A. One of the goals of CHC is to enhance opportunities for community-based living. To support this goal, DHS is requiring CHC-MCOs to provide NHT activities to participants residing in nursing homes who express a desire to move back to their homes or other community-based settings. DHS anticipates that with more support from CHC-MCOs, more individuals will be served in the community.

DHS recognizes that housing is a major barrier in NHT and has developed a housing plan to help address housing barriers. DHS has also established targeted housing as one of the service delivery innovations that CHC-MCOs must support.

Q47. How will the financial management services (FMS) vendor work with the CHC-MCOs?

- A. CHC-MCOs are required to establish agreements and cooperate with the commonwealth procured Fiscal/Employer Agent (F/EA) entity in order that the necessary FMS are provided on behalf of participants.

Q48. How will self-directed workers be paid?

- A. Self-directed workers will be paid through the F/EA procured by the DHS. CHC-MCOs are required to establish agreements and cooperate with DHS' F/EA for the necessary FMS provided on behalf of the participants.

Q49. If a consumer wants to appeal their level of care determination, who do they appeal to?

- A. Participants will receive a notice of determination and right to appeal. The appeal information includes instructions on how to submit an appeal request with DHS.

Questions Added on December 2, 2019

Q50. Will HHAExchange be modified so that the home care provider will know who the SC is?

- A. All three CHC-MCOs agree that knowing who the participant's SC is provides value to providers, and are exploring avenues to have this information added to HHAExchange.

Q51. How do participants select which agency they choose to receive caregiving services from?

- A. Using the CHC-MCO's provider directory, participants have the freedom to choose their service providers from the CHC-MCO's provider network. The CHC-MCO must maintain a web-based provider directory and notify its participants annually of their right to request and obtain a hard copy of the provider directory and where the online directory may be found. To aid new participants in selecting a CHC-MCO, the IEB will also have a master provider directory available on its website that lists all providers participating in the CHC-MCOs networks.

Q52. Will trainings for participants / POAs be on demand in case they are not able to attend live programs?

- A. Participants and their family members/POAs are encouraged to talk with their Service Coordinators about CHC and how it may affect them as well as subscribe to the CHC listserv to receive the latest updates and information about CHC. In addition, a participant-specific training about CHC is at:
<http://www.healthchoices.pa.gov/info/about/community/commpart/index.htm>

Q53. What is meant by NFI and NFCE?

- A. If DHS' independent assessment entity determines that an individual does not need the level of care provided in a nursing facility, the individual is Nursing Facility Ineligible also known as "NFI". If the individual is determined to need the level of care provided in a nursing facility, the individual is known as Nursing Facility Clinically Eligible, or "NFCE". CHC participants must be determined to be NFCE to receive Medicaid funded long-term services and supports in either a nursing facility or through the CHC HCBS waiver.

Q54. Can you provide us with the websites to verify we are in the provider directories with the state and CHC-MCO's?

- A. Provider directories can be viewed at the following links:
- AmeriHealth Caritas: <http://www.amerihealthcaritaschc.com/participants/eng/find-provider/index.aspx>
 - Keystone First: <http://www.keystonefirstchc.com/participants/eng/find-provider/index.aspx>
 - Pennsylvania Health & Wellness: <https://providersearch.pahealthwellness.com/>
 - UPMC: <https://www.upmchealthplan.com/chc/members/documents-and-resources/>
 - IEB: <https://www.enrollchc.com/choose/find-provider>

In addition, the CHC-MCO must notify its participants annually of their right to request and obtain a hard copy of the provider directory and where the online directory may be found.

Q55. What happens to participants if a provider wants to terminate their agreement with a CHC-MCO?

- A. CHC-MCOs have requirements to notify DHS and impacted participants when a provider is terminated from their provider networks. The CHC-MCOs are required to assist participants with selecting new providers. Participants have continuity-of-care protections.

Q56. Why would a participant change CHC-MCOs? Aren't service plans from each CHC-MCO about the same?

- A. Participants may change CHC-MCOs for any number of reasons. A participant may have been auto-assigned to a plan and is now making an informed choice of MCO; the participant may be changing plans due to the MCO's provider network; their Primary Care Physician (PCP) may have left the plan; the participant may prefer another MCO's benefits; or a participant may change plans due to the MCO's customer service. CHC-MCOs may have differing value-added services.

Q57. Does a health care entity need to contract for individual practitioners for each CHC-MCO and every office site to obtain contacts for each location? Or does one contract fit for one Medicaid (MPI)?

- A. Each practitioner would need to be credentialed by a CHC-MCO however, the contract may be at the group/practice level. Providers should work with the individual CHC-MCOs regarding the network contract agreements.

Q58. There is a perception that MCOs are pushing participants to participant-direction vs the agency model of service. Is this the plan?

- A. As part of the person-centered planning process, the CHC-MCOs must offer participants who are eligible for HCBS the opportunity to self-direct PAS through one of two models – Employer Authority or Budget Authority, also known as Services My Way. The participant's decisions around participant-directed services must be documented in the participant's PCSP.

Q59. Can a family member terminate a participant's agency relationship?

- A. Some participants may use a representative to direct their HCBS, and family members or legal guardians may have a role to assist people under guardianship.

Q60. How will PAS providers be notified of an MCO change?

- A. The current Eligibility Verification System (EVS) will identify CHC participants and their CHC-MCO. EVS will display the CHC-MCO plan code information along with the participant's PCP. In addition, the gaining CHC-MCO is responsible to contact all providers on the participant's PCSP.

Q61. When a participant calls a CHC- MCO, what is their policy for return phone calls?

- A. Please see Q18 in the Service Coordination section of this document.

Q62. How does the care management plan interface with the PCSP?

- A. The CHC-MCO must develop and implement a written, holistic PSCP for each participant who requires LTSS. The PCSP must address how the participant's physical, cognitive, and behavioral health needs will be managed, including how Medicare coverage (if the participant is dual eligible) will be coordinated and how the participant's LTSS will be coordinated. Additionally, the CHC-MCO must develop and implement a written care management plan for participants who do not require LTSS but who have unmet needs, service gaps, or a need for Service Coordination.

See Sections V.G.1 and V.H. of the CHC Agreement for the required components of the Care Management Plan.

Q63. Who is responsible to give PAS providers updated service plans?

- A. The SC must communicate the service plan content to the provider or providers to ensure that service delivery matches the approved PCSP. The SC must provide an authorization of service that includes the type, scope, amount, duration, and frequency of services to be provided and any preferences the participant has related to service delivery.

Q64. How do providers receive referrals?

- A. The CHC-MCOs must provide participants with choice of providers within its network. If the participant does not choose a provider, the CHC-MCO will work with the participant to select an appropriate provider. The CHC-MCO will send the selected provider a referral/notification. Participants have the right to change providers at any time.

Q65. What procedures do the CHC-MCOs have to assure that a back-up plan is in place and functioning?

- A. As required by the CHC Agreement, the participant's PCSP must document both an individualized and an emergency back-up plan which address a range of circumstances such as staffing, weather events, power outages, travel restrictions, etc. and must assure the health and welfare of the participant. The participant's Service Coordinator must review the PCSP quarterly to validate that the back-up plans are current and working, and update the back-up plan as necessary, or if the back-up has failed at any point.

Incident Management

Q1. How will critical incident reports be managed by the CHC-MCOs?

- A. The CHC-MCO must comply, and require their home and community-based services (HCBS) and nursing facility (NF) network providers to comply, with the Department of Human Services' (DHS) critical incident reporting and management, provider-preventable condition, and provider serious adverse events reporting requirements.

CHC-MCOs must also ensure that network providers comply with the reporting requirements established in the Older Adult Protective Services Act (OAPSA) and the Adult Protective Services Act (APSA).

CHC-MCOs must investigate critical events or incidents reported by network providers and subcontractors and report the outcomes of these investigations using DHS' Enterprise Incident Management (EIM) System.

Q2. Once CHC is implemented, what system will HCBS providers use to report critical incidents?

- A. After CHC is implemented in a zone, CHC-MCOs and their network providers and subcontractors must report critical events or incidents via EIM.

Q3. After CHC implementation, will Medicare certified home health agencies still be required to submit events to the Pennsylvania Department of Health (DOH)?

- A. Medicare and state required reporting responsibilities will not change after CHC is implemented in a zone. In addition, home health agencies and other HCBS providers must continue to report critical incidents for CHC participants in EIM.

Q4. Where will agencies report critical incidents for HCBS participants to -- the CHC-MCOs, the Office of Long-Term Living (OLTL), the Department of Aging?

- A. Critical incidents as defined by OLTL must be reported through EIM. CHC-MCOs will be responsible to ensure their providers understand when reports are required, are trained to use EIM, and monitor to ensure incidents are being reported. All incident reports must be entered into EIM. In addition, providers must continue to make mandatory reports in accordance with APSA and OAPSA and to law enforcement for incidents that meet the specific requirements of the APSA and OAPSA laws.

Q5. Once CHC is implemented, will incident reporting change for NFs?

- A. NFs should report critical incidents, including preventable serious adverse events, to the CHC-MCOs. NFs will continue to submit reportable events to the DOH through DOH's system.

Reportable events include:

- I. Complaint of resident abuse, confirmed or not. Abuse is defined in 42 CFR 483.13(b) and 28 PA Code 201.3.
 - i. Verbal
 - ii. Sexual
 - iii. Physical
 - iv. Mental
 - v. Involuntary seclusion
 - vi. Neglect
- II. Death due to medication error or adverse reaction to medication
- III. Death due to malnutrition, dehydration or sepsis
- IV. Elopement inpatient
- V. Reportable diseases, referenced 28 PA Code 211.1 and Chapter 27 of Administrative Code/211.1(a)
- VI. Misappropriation of resident property
- VII. Notification of interruption/termination of any service vital to the continued safe operation of the facility or the health and safety of its personnel, including but not limited to anticipated or actual termination of utilities
- VIII. Other - Any event that could seriously compromise quality assurance or *resident safety and does not fit under any other category use this one*. Examples:
 - i. Leave of Absence (LOA) misadventure
 - ii. Unsafe practices by outside individuals
 - iii. Unsafe practices by the resident
- IX. Resident neglect. Reference 42 CFR 483.13(c), 28 PA Code 201.3, and Act 13 of 1997 for definitions.
- X. Rape
- XI. Receipt of strike notice
- XII. Significant disruption of service due to disaster such as fire, storm, flood, or other occurrence
- XIII. Transfer/admission to hospital because of injury/accident
- XIV. Unlicensed practice of regulated profession

The CHC-MCOs should determine which reportable events NFs should also report to the CHC-MCO.

Q6. What is the definition of a critical incident and will the definition be the same for all CHC-MCOs?

A. All CHC-MCOs are required to use the same definition of critical incidents for CHC HCBS

waiver participants. Critical incidents are defined as:

- I. Death (other than by natural causes);
- II. Serious injury that results in emergency room visits, hospitalizations, or death;
- III. Hospitalization except in certain cases, such as hospital stays that were planned in advance;
- IV. Provider or staff misconduct, including deliberate, willful, unlawful, or dishonest activities;
- V. Abuse, which includes the infliction of injury, unreasonable confinement, intimidation, punishment, mental anguish, or sexual abuse of a participant. Types of abuse include, but are not necessarily limited to:
 - i. Physical abuse, defined as a physical act by an individual that may cause physical injury to a participant;
 - ii. Psychological abuse, defined as an act, other than verbal, that may inflict emotional harm, invoke fear, or humiliate, intimidate, degrade or demean a participant;
 - iii. 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
 - iv. Verbal abuse, defined as using words to threaten, coerce, intimidate, degrade, demean, harass, or humiliate a participant;
- VI. Neglect, which includes the failure to provide a participant the reasonable care that he/she requires, including, but not limited to, food, clothing, shelter, medical care, personal hygiene, and protection from harm.
- VII. 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;
- VIII. 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;
- IX. 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;
- X. 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
- XI. Medication errors that result in hospitalization, an emergency room visit or other medical intervention.

Q7. If providers are still going to report critical incidents for HCBS participants through EIM, does that mean that the Home and Community Services Information System (HCSIS) is not being dismantled?

- A. Critical incidents, as defined by OLTL, must be reported for CHC HCBS waiver participants through EIM. After CHC implementation, providers will only use HCSIS for ACT 150 and OBRA waiver participants.

Questions Added on December 2, 2019

Q8. What EIM training will providers receive?

- A. The CHC-MCOs are responsible for ensuring their network providers are trained to use EIM. Providers should work with their CHC-MCOs to receive access and training on EIM.

Q9. Will critical incidents for the Aging waiver be reported through EIM?

- A. With the implementation of CHC, individuals being served by the Aging waiver will be enrolled in the CHC waiver; the Aging waiver will terminate on December 31, 2019. Once CHC is implemented in each zone, CHC-MCOs and their network providers and subcontractors must report critical events or incidents via EIM. Please see Q4 in the Incident Management section of this document for more information.

Q10. Who reviews EIM – the state or the CHC-MCOs?

- A. The CHC-MCOs are required to establish a process to receive and manage critical incident reports. DHS has established an operations report that monitors and addresses the CHC-MCO's administration of the incident management process. DHS also retains the right to review any incident reports or internal documentation, conduct its own investigations and require corrective actions by the CHC-MCO.

Q11. Do providers need to have certified investigators?

- A. No, direct service providers are not required to have certified investigators. The CHC-MCOs are responsible for investigating critical incidents.

Q12. Do the CHC-MCOs need to have certified investigators?

- A. No, however the CHC-MCOs must investigate critical events or incidents that are reported by network providers and subcontractors and report the outcomes of these investigations to DHS.

Q13. When should critical incidents be reported in EIM?

- A. Within 48 hours, the CHC-MCO staff or network provider and subcontractors that discovers or has independent knowledge of a critical incident must submit a critical incident report in EIM. If the incident occurs over the weekend or a holiday, a written report must be entered the first business day after the incident occurred.

Q14. Do we need to report critical incidents separately per CHC-MCO or one time through EIM?

- A. Please see Q4 in the Incident Management section of this document.

Q15. Do day programs continue to report to DHS as we have or will the process change?

- A. Adult Daily Living Centers (day programs) who are serving OLTL waiver participants must report critical incidents as defined in the CHC waiver and in MA Bulletin 05-15-02, Critical Incident Management. Please see Q4 in the Incident Management section of this document and MA Bulletin 05-15-02 at:

https://www.dhs.pa.gov/docs/Publications/Documents/FORMS%20AND%20PUBS%20OLTL/c_1_71054.pdf for additional information.

Adult Daily Living Centers may have additional incident reporting obligations as part of their licensure requirements.

Q16. What do you term critical?

- A. Please see Q6 in the Incident Management section of this document.

Q17. Can you define unplanned hospitalization?

- A. Being admitted to the hospital for a non-routine medical procedure that was not scheduled or planned in advance is an unplanned hospitalization and considered a critical incident; a routine hospital visit for lab work or routine treatment of an illness of a participant is not an unplanned hospitalization and is not considered a critical incident. Please refer to Q6 in the Incident Management section of this document and MA Bulletin 05-15-02, Critical Incident Management, at:

https://www.dhs.pa.gov/docs/Publications/Documents/FORMS%20AND%20PUBS%20OLTL/c_1_71054.pdf

Q18. Are CHC-MCO's responsible for investigating critical incidents or is the direct service provider?

- A. The CHC-MCOs must investigate critical events or incidents reported by network providers and subcontractors and report the outcomes of these investigations to DHS.

Q19. Who is responsible for reporting ER visits/hospital admissions in EIM? Would it be the CHC-MCO, service coordinator (SC), or direct service provider? What if the CHC-MCO/SC finds out first?

- A. The CHC-MCO staff or network provider and subcontractors that discovers or has independent knowledge of a critical incident must submit a critical incident report in EIM within 48 hours. If the incident occurs over the weekend or a holiday, a written report must be entered the first business day after the incident occurred.

Q20. When do missed services need to be reported and how do they get reported?

- A. Providers are responsible for staffing all services on the participant's Person-Centered Service Plan and authorized by the CHC-MCO. Services that are not delivered for one hour or more of a designated shift to participants who utilize home health skilled care, home health aide services and/or Personal Assistance Services, must be reported as missed services to the CHC-MCO through the mechanism identified by the CHC-MCO. The CHC-MCOs report this data to DHS through an operations report. All non-delivered or late trips for non-emergency medical transportation and non-medical transportation services must also be reported.

Service Interruptions, defined as any event that results in the participant's inability to receive services and that places the participant's health and or safety at risk, are considered critical incidents and must be reported through EIM as a critical incident. Not all missed services as defined above, are considered Service Interruptions.

Q21. If a participant misses a day at an adult day center, is this considered a missed service? Do missed days get reported through HHAExchange, the SC, etc.?

- A. If a participant misses a day at an adult day center and their health and safety is at risk, this would be considered a critical incident. Planned days missed at an Adult Daily Living Center are not considered missed services for the purpose of reporting through EIM or HHAExchange. However, if a participant misses a significant number of days at the Adult Daily Living Center, the provider should discuss this with the participant's SC.

Q22. Under what category does "missed shift" fall in HHAExchange?

- A. Any visit in HHAExchange can be marked as "missed visit." When doing so, the system will ask to select a reason for missed visit from dropdown options, defined by OLTL, as well as an action taken. This must be entered in order for the system to save the visits as "missed". There are 3 options to select to report this information.

Q23. Is EIM available to Durable Medical Equipment, Prosthetic, Orthotic and Supplies (DMEPOS) vendors?

- A. All providers who are enrolled as a MA waiver provider with OLTL are required to report critical incidents through EIM. Please work with your CHC-MCO to receive access and training on EIM.

Q24. Incident Reporting – Is it still within 24 hours for reporting?

- A. CHC-MCO staff or network providers and subcontractors that discover or has independent knowledge of a critical incident must submit a critical incident report in EIM within 48 hours of discovery. If the incident occurs over the weekend or a holiday, a written report must be entered the first business day after the incident occurred.

Independent Enrollment Broker

Q1. What is the current status of the Independent Enrollment Broker (IEB) procurement?

- A. The Enrollment Services Request For Applications (RFA) that includes IEB and Beneficiary Support Services (BSS) is targeted for release in early 2020.

Q2. Will the IEB continue to provide enrollment services or will it go back to the Area Agencies on Aging (AAAs)?

- A. The IEB, regardless of vendor, will continue to provide enrollment services. Federal rules require that the IEB must be conflict free, and, as such, cannot be a related party to a CHC-MCO or Medicaid provider.

Q3. Will the Department of Human Services (DHS) or the CHC-MCOs contract with the IEB?

- A. DHS will enter into a grant agreement with the IEB.

Q4. Who will oversee the IEB's performance and what steps are being taken to improve performance?

- A. DHS has oversight responsibility of the IEB's performance. DHS expects to issue an RFA to procure an IEB vendor for CHC and other OLTL Programs in 2020. The new IEB procurement will provide for enhanced oversight through increased reporting requirements and imposition of specific performance standards regarding, timeliness of enrollment functions, compliance with corrective action plans and related financial assessment or remedies for non-compliance. In addition, the selected vendor will be required to submit a readiness review plan that addresses items such as staffing, training schedule, enrollment responsibilities, management information systems, and implementation quality management.

Pending completion of the IEB procurement process, DHS has taken steps to incorporate additional performance and reporting requirements and oversight functions into its existing IEB contract. DHS continually monitors the IEB'S performance for compliance with these requirements.

Q5. What is the timeline for the IEB follow-up on referrals for enrollment?

- A. Currently, the IEB is responsible to manage the long-term services and supports (LTSS) application process so that, generally, LTSS applicants receive a final determination on the LTSS application within 90 days. Currently, the IEB must follow up if the Functional Eligibility Determination (FED) is not completed by the Independent Assessment Entity (IAE) within 10 calendar days of a referral. The RFA will impose additional requirements related to follow up on to promote timely enrollments. For example, the selected vendor will be required to arrange for completion of physician certifications if they are not provided by the applicants' own physicians and complete FED for LTSS Applicants during their in-person visit, which must be conducted within 7 calendar days of their referral date.

Q6. What is the IEB's involvement with the new FED tool?

- A. The IEB serves as the entry point for the CHC home and community-based services (HCBS) enrollment process; therefore, the IEB will interact with the IAE. The IEB receives notification from DHS of new CHC participants. The IEB will also receive direct referrals of individuals or individuals may self-refer or be referred to the IEB by third parties. The IEB will collect information from the participant and send an alert to the IAE to complete a FED.

Q7. Will the IEB only be available during the transition to CHC-MCOs?

- A. No. The IEB's role was expanded in 2018 to include ongoing CHC-related functions. In CHC zones, the IEB will continue to assist CHC-MCO participants after transition as well as assisting OBRA waiver and Act 150 participants. In those areas where CHC has not yet been implemented, the IEB will continue to facilitate the LTSS eligibility process for individuals seeking LTSS waiver services.

Q8. Does the IEB come into the nursing facilities (NFs)?

- A. Yes, IEB representatives may come into a NF. Currently, the IEB assists NF residents who are applying for LTSS waiver services with the LTSS eligibility process. Once CHC is implemented in a zone, the IEB will also assist individuals who are residing in NFs to select or change his/her CHC-MCO plan or, if eligible, to educate on the Living Independence for the Elderly (LIFE) program. In providing enrollment assistance to these individuals, the IEB will coordinate and cooperate with the residents' NFs. At a minimum, the IEB will work with the NFs in scheduling visits with and facilitating clinical and financial eligibility determinations for NF residents. If an LTSS applicant designates a NF as a contact, the IEB will also provide the NF with information relating to the status of the individual's LTSS application.

Q9. How will the IEB communicate with NF staff or with the CHC-MCO or both?

- A. The IEB will communicate with both NF staff and CHC-MCO staff when performing enrollment activities for NF residents. The IEB may contact NFs and CHC-MCOs by telephone, in writing, by email, or in person.

Q10. What is the role of the IEB for a Medical Assistance (MA) individual residing in a NF?

- A. The IEB assists NF residents and NF staff in managing the CHC enrollment process. This includes selecting a CHC-MCO, making referrals to a local LIFE provider, processing requests to change CHC-MCO plans, providing enrollment materials, assisting CHC participants and LTSS applicants through the MA clinical and financial eligibility process, and providing information on nursing home transition.

Q11. Does the facility or IEB complete the MA application process?

- A. NFs can originate the enrollment application process through the Commonwealth of Pennsylvania Application for Social Services (COMPASS) if they are a community partner. NFs may also complete a paper application and submit it to the County Assistance Office (CAO). NFs may also contact the IAE to begin the FED process.

Applications not originated by the IEB will be transmitted to the IEB to send out enrollment materials and assist the CHC participant with CHC-MCO plan selection.

Q12. Is there a fee to use the IEB by the NF?

- A. The IEB will be reimbursed by DHS for services it provides.

Q13. How far will the IEB go to secure the necessary information required and will the CAOs use their regulatory authority to secure documents?

- A. The IEB is required to assist an applicant in completing an application for LTSS when providing initial assistance and to perform other tasks as required by the program.

Q14. How do current NF residents on fee-for-service get access to the IEB?

- A. The IEB assists NF residents who are applying for HCBS.

Medicare

Q1. If a dual eligible individual already has a Medicare Advantage plan, will he or she be required to enroll in a new Medicare plan when they join a CHC managed care organization (MCO)?

- A. An individual is not required to change his or her Medicare Advantage Plan when the individual enrolls in CHC. The Department of Human Services is requiring each CHC-MCO to have a companion Medicare Dual Eligible Special Needs Plan (D-SNP) and the individual may want to consider enrolling in that D-SNP.

Q2. Are there continuity-of-care requirements for nursing facility (NF) residents who have been admitted to a hospital or have a primary care physician that is not included in the CHC-MCO's provider network?

- A. NF residents who are dual eligible can keep their Medicare primary care physician (PCP) for both CHC and Medicare. For all participants, the CHC-MCO must comply with continuity-of-care requirements for continuation of providers, services, and any ongoing course of treatment as outlined in MA Bulletin 99-03-13, Continuity of Care for Recipients Transferring Between and Among Fee-for-Service and Managed Care Organizations.

Q3. Will the way a participant currently receives Medicare change after CHC is implemented?

- A. Dual eligible participants will continue to have all of the Medicare options they have today, including Original Medicare and Medicare Advantage managed care plans. In addition, they will have a more coordinated approach and may receive additional benefits by enrolling in their CHC-MCO's companion D-SNP. If a participant is in Original Medicare or has chosen a Medicare option through a different company, the CHC-MCO is still responsible for coordinating with the participant's Medicare plan and providers. The participant's Medicare will not change unless the participant decides to change it.

Q4. If an individual chooses a D-SNP through a different company than one of the three CHC-MCOs, how will they receive coverage of the dental and vision extras provided through the adult package? Will the participant get the advantages of both their D-SNP and CHC-MCO plan or will they only be able to take advantage of one or the other?

- A. If a participant is enrolled in a D-SNP and a CHC-MCO plan, the participant is entitled to the benefits provided by both the Medicare and Medicaid plans. For example, if the participant requires dental cleanings and a tooth extraction, the participant may receive their dental cleanings under the D-SNP and their tooth extraction from the CHC-MCO plan. This applies whether the participant is enrolled in a companion plan or in a D-SNP plan through a different company than the CHC-MCO plan. If both the D-SNP and the CHC-MCO plan cover the same service, the participant must exhaust the coverage available under the D-SNP before his or her CHC-MCO will pay.

Q5. If a dual eligible participant is enrolled in a CHC-MCO plan and the participant needs to see a podiatrist, does the podiatrist need to be in their CHC-MCO network and what card(s) would the participant show the provider?

- A. Dual eligible participants can see their Medicare-participating podiatrist even if the podiatrist is not in the participant's CHC-MCO provider network. The participant should show the podiatrist the identification cards for all his or her healthcare coverage. In this example, the participant should show his or her Medicare, Access, and CHC-MCO identification cards. The podiatrist will bill the CHC-MCO for the participant's Medicare co-insurance and deductibles.

Q6. Can a participant have a Medicare product different from the CHC-MCO?

- A. Yes, dual eligible participants will continue to have all of the Medicare options they have today, including Original Medicare and Medicare Advantage managed care plans. In addition, they will have a more coordinated approach and may receive additional benefits by enrolling in their CHC-MCO's companion D-SNP. If a participant is in original Medicare or has chosen a Medicare option through a different company, the CHC-MCO is still responsible for coordinating with the participant's Medicare plan and providers. The participant's Medicare will not change unless the participant decides to change it.

Q7. Will all three CHC-MCOs be offering their Medicare product on Day 1 of CHC implementation?

- A. Yes, all three CHC-MCOs will be offering their Medicare product on Day 1 of CHC implementation. The name of the Medicare products for the CHC-MCOs are: AmeriHealth Caritas VIP Care, Allwell Dual Medicare from Pennsylvania Health and Wellness (Centene) and UPMC for Life Dual.

Q8. If a CHC participant has Medicare, or a supplemental insurance and Medicaid, how does this impact the participant?

- A. CHC participants must exhaust their available Medicare or other third-party resource (TPR) coverage before CHC will cover a service or item. The CHC-MCO must pay Medicare deductibles and coinsurance amounts relating to any Medicare-covered service for dual eligible participants not to exceed the contracted CHC-MCO rate. The CHC-MCO will not be responsible for copayments or cost-sharing for Medicare Part D prescriptions. All outpatient drugs are copay exempt for MA beneficiaries in long-term care or intermediate care facilities.

Q9. If a CHC participant has Medicare, or a supplemental insurance and Medicaid, how does this impact the provider?

- A. When a CHC participant has Medicare or supplemental insurance coverage for a service or item, providers must bill the Medicare program and/or the supplemental insurance first before billing the participant's CHC-MCO. Some Medicare Advantage plans and Special Needs Plans (SNP) may cover personal assistance services (PAS). The service coordinator (SC) and PAS agency are responsible for verifying coverage of services with other payers. For more information, the PAS agency should check with the CHC-MCO to ensure that they are following the CHC-MCO's billing procedures correctly.

Q10. How will hospice services in a NF be provided and reimbursed under CHC?

- A. Under CHC, the hospice provider will bill the CHC-MCO for hospice services rendered to CHC participants which are not covered by the participant's Medicare hospice benefit. The NFs will bill the CHC-MCO for the resident's room and board.

Q11. Do I still need my Medicare Advantage plan?

- A. Yes, you still need to have a Medicare plan. Dually-enrolled participants who are eligible for both Medicare and Medicaid have the option of keeping their Medicare Advantage plan or selecting a new one.

Q12. If you have Medicare and Medicaid, who pays the Medicare premiums?

- A. Payment of Medicare premiums will not change under CHC. Medicare premiums will be covered by the Medicaid program.

Q13. Will Medicare Part D medications still be in effect under CHC?

- A. Medicare Part D will not change under CHC. In addition, the CHC-MCO must provide coverage of prescription and over the counter medications that are not covered by a Medicare Part D.

Q14. How will CHC work with Medigap insurance?

- A. Since CHC covers Medicare deductibles and coinsurance amounts, CHC participants may not need a Medigap policy. Please contact the Apprise program at 1-800-783-7067 for additional assistance.

Questions Added on December 2, 2019

Q15. If a participant is enrolled in a Medicare Advantage Plan, how will a provider know what supplemental benefits are covered by that plan?

- A. The SC is responsible for verifying coverage of services with other payers, including supplemental benefits that may be offered through a Medicare Advantage Plan or D-SNP, and coordinating the provision of these services with CHC direct service providers. As noted in Q9, when a CHC participant has Medicare or supplemental insurance coverage for a service or item, providers must bill the Medicare program and/or the supplemental insurance first before billing the participant's CHC-MCO.

Q16. What exactly is D-SNP?

- A. SNPs are a type of Medicare Advantage plan that limits enrollment to Medicare beneficiaries who meet certain eligibility criteria. These plans cater their benefits to serve the unique needs of its members. A D-SNP is a type of SNP that serves individuals who have both Medicare and Medicaid benefits (also known as dual eligibles).

Q17. Will the CHC-MCO's be moving more participants to Medicare providers?

- A. It has always been a requirement that services be provided under Medicare or TPR prior to seeking coverage under Medicaid. This will not change under CHC. When a CHC participant has Medicare coverage for a service or item, that service or item must be provided through a Medicare certified provider and billed to the Medicare program before billing the participant's CHC-MCO.

Network Adequacy

Q1. How many hospice providers are enrolled for CHC?

- A. CHC-MCOs must have a provider network that meets anticipated utilization, Medicaid enrollment, and meet travel and distance standards for CHC covered services. The CHC-MCOs and the Independent Enrollment Broker will publish online directories that list all contracted CHC providers. The CHC-MCOs can also be contacted to obtain information about provider networks.

Q2. How do you get existing providers like ambulance services to contract with CHC-MCOs?

- A. The Department of Human Services (DHS) has provided the CHC-MCOs with lists of all currently enrolled Medicaid providers, including ambulance providers, to assist with provider contracting. The CHC-MCOs may determine their network contracting approach and network composition in accordance with the long-term services and supports (LTSS) continuity of care (COC) and network access and adequacy standards outlined in the CHC Agreement. Providers should contact the CHC-MCOs to request how the MCOs will approach contracting.

Q3. Are CHC-MCOs looking to reduce the number of providers in their network subsequent to the 180- day COC period? If so, by what number?

- A. Following the 180-day COC period, the CHC-MCO may adjust its provider network in accordance with the network access and adequacy standards outlined in the CHC Agreement. DHS will receive monthly reports on all provider terminations to determine how many participants are affected and if network adequacy is impacted. DHS will re-evaluate network adequacy at the end of the 180-day COC period to ensure consumers have access to LTSS.

The CHC-MCOs will likely seek to use contracted providers who can help meet the goals of improved coordination of care and improving the quality of services. The CHC-MCOs will have their own criteria for measuring provider performance. Providers may want to request this information from the CHC-MCO during the contracting process.

Q4. For patient choice and network adequacy, has the Department of Health (DOH) been involved?

- A. DOH has worked with DHS and stakeholders in developing network adequacy standards for home and community-based services (HCBS). DOH must certify that the CHC-MCOs meet network adequacy standards for all covered services in accordance with 28 Pa. Code § 9.679 in order for the CHC-MCO to receive a Certificate of Operating Authority.

Q5. How will DHS determine that the CHC-MCOs have adequate provider contracts for HCBS and nursing facility (NF) services?

- A. DOH currently evaluates the NF network adequacy during network review for all health maintenance organizations (HMOs), including HealthChoices MCOs, as part of issuing the required Certificate of Operating Authority to operate an HMO in Pennsylvania. This evaluation is done in accordance with 28 Pa. Code § 9.679.

Section 9.679(d) of the managed care regulations states that a plan shall provide for at least 90% of its enrollees in each county in its service area, access to covered services that are within 20 miles or 30 minutes travel from an enrollee's residence or work in a county designated as a metropolitan statistical area (MSA) and within 45 miles or 60 minutes travel from an enrollee's residence or work in any other county.

National network adequacy standards do not exist for HCBS providers. DHS has worked with stakeholders and consumers to determine network adequacy standards. DHS is gathering information to establish a baseline of the number of full-time equivalents (FTE) that are potentially needed to continue to provide HCBS and meet the needs of the participants. This process will look at the number of direct care workers' (DCW) hours paid under fee-for-service (FFS). CHC-MCOs must demonstrate they have the ability to meet this level of hours. DHS is establishing an operations report that will monitor and address the CHC-MCO's ability to provide services identified in the Person-Centered Service Plan.

Recognizing the importance and the challenges with ensuring a sufficient supply of workers, CHC includes a goal of innovation on workforce issues. DHS is proposing annual measures of DCW availability and retention as part of the quality strategy. CHC-MCOs are responsible to implement innovations that can improve these measures over time.

Q6. Providers are to report to CHC-MCOs the number of FTEs of DCWs needed. Some providers may be hesitant to report actual needs, out of concerns that CHC-MCOs may not contract with them if they reveal staffing needs. How can providers give an accurate picture of the shortage of DCWs?

- A. Providers currently providing services should contact the CHC-MCOs to discuss becoming part of the CHC-MCOs' network. Accurately identifying staffing needs will promote a collaborative partnership with the CHC-MCOs, which are responsible for developing the direct provider workforce.

Q7. What is the timeline for determining CHC-MCOs meet network adequacy?

- A. Network adequacy is a major part of the CHC-MCO readiness review process that occurs prior to implementation of each zone. The CHC-MCOs are required to submit monthly updates on network development. DOH and DHS review these submissions and identify areas of concern. DHS holds weekly readiness review calls with the CHC-MCOs and discusses items including network adequacy. DOH must certify that the CHC-MCOs meet network adequacy as part of obtaining a required Certificate of Authority to operate in Pennsylvania.

Q8. What plans exist to meet "community" needs in rural counties that do not have services available at this time? Will it affect the NF financially if there is not any available place to discharge to?

- A. CHC-MCOs must comply with requirements in the agreement to provide required services, including community-based services. NFs should be reimbursed in accordance with contracted per diem rates for services and should discuss any concerns related to community need with the CHC-MCOs.

Q9. Will CHC-MCOs have physician extenders in the facilities?

- A. NFs should discuss the use of physician extenders with the CHC-MCOs.

Q10. Are DHS and DOH tracking the CHC-MCOs progress in reaching out to the providers?

- A. The CHC-MCOs have been required to submit monthly updates on network development. DOH and DHS have reviewed these submissions and identified areas of concern. DHS holds weekly readiness review calls with the CHC-MCOs and discusses items including network adequacy. DOH must certify that the CHC-MCOs meet network adequacy as part of obtaining a required Certificate of Authority to operate in Pennsylvania.

Questions Added on December 2, 2019

Q11. When calculating a FTE, what is the calculation based on?

- A. Each agency should calculate the number of FTEs utilizing the agency's standard for full-time. Providers are to report to CHC-MCOs the number of FTEs of DCWs needed to staff the total number of service hours authorized for their agency.

Q12. What are the criteria for termination of a provider?

- A. This topic should be discussed with the CHC-MCOs. The CHC-MCOs will establish their own criteria for continuing contracts with providers. The CHC-MCOs typically seek providers who help them meet the requirements in the CHC Agreement, goals of improved coordination of care and improving the quality of services.

Q13. Will the CHC-MCOs ever go to a single provider for specific services (i.e., a single provider for personal emergency response system (PERS) etc.) once roll-out is complete?

- A. Following the one hundred eighty (180) day period, the CHC-MCO may adjust its provider network in accordance with the network access and adequacy standards outlined in the CHC Agreement, which stipulates that the CHC-MCOs must have a provider network that meets anticipated utilization, Medicaid enrollment, and meet travel and distance standards for CHC covered services. In addition, the CHC-MCOs must provide participants with choice of providers within its network.

Q14. Are the CHC-MCOs required to have a certain percent of in-network providers?

- A. Per Exhibit T, Provider Network Composition/Service Access, of the CHC Agreement, CHC-MCOs must ensure that its provider network is adequate to provide its participants with access to quality care through participating professionals, in a timely manner, and without the need to travel excessive distances. DHS may require additional numbers of specialists, ancillary, and LTSS providers should it be determined that geographic access is not adequate. The CHC-MCO must make all reasonable efforts to honor a participant's choice of providers who are credentialed in the network. If the CHC-MCO is unable to ensure a participant's access to provider or specialty provider services within the provider network, within the travel times established in Exhibit T, the CHC-MCO must make all reasonable efforts to ensure the participant's access to services within the established travel times through out-of-network providers. Please also see Q5 in the Network Adequacy section of this document and Exhibit T of the CHC Agreement for additional information.

Organized Health Care Delivery System

Q1. As a current waiver provider, the Area Agency on Aging (AAA) employed staff directly produces and delivers meals to home bound participants and to congregate centers. In CHC, does the AAA need to be enrolled in the Pennsylvania Medical Assistance (MA) Program?

- A. All CHC-MCO providers must be enrolled in MA and must be credentialed by and contracted with a CHC-MCO to be part of the CHC-MCO's Provider Network in order to receive reimbursement for a CHC participant. All subcontracted providers currently providing home delivered meals, community transition, non-medical transportation, home adaptations, personal emergency response systems (PERS), vehicle modifications, and/or assistive technology must be enrolled directly as MA providers with the Office of Long-Term Living (OLTL). Subcontracted providers must enroll as an MA provider before the end of the continuity of care (COC) period in each CHC Zone to be eligible to contract with CHC-MCOs.

Q2. If an agency provides Personal Emergency Response Services (PERS) through their Home Care Operations Tax ID company and MA provider number, do you need an additional MA number for PERS?

- A. No, an additional MA number is not necessary. Home care agencies are permitted to provide PERS. The home care agency should review their provider profile in PROMISE™ to confirm their enrollment includes the appropriate Provider Type and Specialty, e.g. 05/025, 59/025.

Q3. Would a home adaptation company enrolled in the Pennsylvania MA Program that is short of plumbers have to wait for one to be enrolled to complete an adaptation? Do subcontractors, such as plumbers, providing home adaptations need to enroll in MA?

- A. Home adaptations can be provided by a durable medical equipment (DME) provider or a contractor. The DME provider or contractor providing home adaptations must be enrolled as a MA provider with OLTL and contracted with the CHC-MCO in order to provide and be reimbursed for services. A contractor enrolled to provide home adaptations can choose to provide all services or subcontract for services. Subcontractors who will be reimbursed by the contractor do not need to enroll in MA. All contractors enrolled to provide home adaptations must ensure that whatever adaptations they provide meet all applicable standards, including local codes.

Q4. Revised January 26, 2018

- A. This question was consolidated with Q6.

Q5. If a PERS or home modification provider is already sub-contracted with an Area Agency on Aging (AAA), do they still need to enroll themselves as a provider with each CHC-MCO?

- A. All CHC-MCO providers must be enrolled in the Pennsylvania MA program and must be credentialed by and contracted with a CHC-MCO to receive reimbursement for a CHC participant. All subcontracted providers providing home delivered meals, community transition, non-medical transportation, home adaptations, PERS, vehicle modifications, and/or assistive technology must be enrolled directly as MA providers with OLTL. Subcontracted providers must enroll as an MA provider before the end of the COC period in each CHC Zone to be eligible to contract with CHC-MCOs.

Questions Added on December 8, 2017

Q6. If a participant currently has a PERS and that provider does not have a MA provider number, will the participant lose their PERS system or will the CHC-MCO ensure they continue to have their PERS system?

- A. The CHC-MCOs are required to cover PERS. PERS providers who are currently enrolled as a subcontractor to a service coordination entity must enroll in the Pennsylvania MA Program with OLTL and contract with CHC-MCOs to provide services to CHC participants. PERS is subject to the COC provision. After the COC time period, CHC-MCOs can determine their provider network. Providers must agree to contractual terms and meet CHC-MCO participation requirements.

Participant Enrollment

Q1. How will the auto-assignment work?

- A. If an individual does not select a CHC-MCO, the Independent Enrollment Broker (IEB) will assign the individual to a plan using criteria that align with the way in which the individual is currently receiving Medicare and Medicaid services and take into account the individual's nursing facility (NF) provider (if any) and current primary care physician. If the IEB is unable to make a plan assignment using these criteria, the individual will be auto-assigned to a CHC-MCO by the Department of Human Service's (DHS) computer system using a process that keeps family members enrolled with the same CHC-MCO and otherwise provides for distribution of participants across CHC- MCOs. Even though an individual is assigned to a plan either by the IEB or DHS, the individual is free to select a different plan at any time for any reason, including for example, if his or her current providers are in a different CHC MCO's provider network.

Q2. What is the service coordinators (SC) role in assisting the individual with getting enrolled for long-term services and supports (LTSS)?

- A. SCs are responsible to refer individuals to the IEB, inform participants about available LTSS, required needs assessments, the participant-centered service planning process, service alternatives, service delivery options (opportunities for participant-direction), roles, rights, risks and responsibilities, fair hearing rights and assist with fair hearing requests when needed and upon request.

Q3. How often can participants change plans? Can they switch mid-month?

- A. A participant has the right to change his or her CHC-MCO at any time; however, the participant's enrollment in the new plan will take effect depending on when the participant requests the transfer. Generally, if the participant requests to transfer to a new plan during the first half of the month, his or her enrollment in the new plan will be effective on the first day of the following month. If the participant requests to transfer during the second half of the month, his or her enrollment in the new plan will be effective on the first day of the second month following the transfer request. For example, if a participant makes a request to transfer to a new plan on March 2, 2018, the participant will be enrolled in the new plan effective April 1, 2018. If the participant makes the request on March 16, 2018, the participant will be enrolled in the new plan effective May 1, 2018.

The CHC-MCO is prohibited from restricting participants from changing CHC-MCOs. SCs and the IEB will assist participants in facilitating a seamless transition between CHC-MCOs.

Q4. What is the most efficient method for a new participant to learn about CHC-MCOs?

- A. Participants should read all of the materials sent to them and attend informational meetings. Participants should also review communication materials on the DHS website:
<http://www.healthchoices.pa.gov/info/about/community/commpart/index.htm>

Q5. Revised March 20, 2018 – Question and response moved to Medicare section

Q6. How do NF residents contact the IEB to begin the process of enrolling in CHC and describe the enrollment process?

- A. NF residents and their representatives may contact the IEB by telephone, in writing, or by email using the IEB hotline and website. In addition, IEB representatives may initiate contact with NF residents and come into a NF to provide them choice counseling and enrollment assistance.

Currently, the IEB assists NF residents who are applying for LTSS Waiver services with the LTSS eligibility process. Once CHC is implemented in a zone, the IEB will also assist NF residents and other LTSS applicants who are applying to receive NF services through CHC with the LTSS eligibility process, and to select or change their CHC-MCO plan. The IEB will also provide information about the LIFE program to individuals who may be eligible to participate in that program.

In providing enrollment assistance to NF residents, the IEB will coordinate and cooperate with the residents' NF. At a minimum, the IEB will work with the NFs in scheduling visits with and facilitating FED and financial eligibility determination for NF residents. If an LTSS applicant designates a NF as a contact, the IEB will also provide the NF with information relating to the status of the individual's LTSS Application.

Q7. Revised March 20, 2018 – Question and response moved to Medicare section

Q8. Is the participant supposed to select all three CHC-MCOs or just one of the three?

- A. A participant will select one CHC-MCO. AmeriHealth Caritas, Pennsylvania Health and Wellness (Centene) and UPMC Community HealthChoices were selected to provide services on a statewide basis. AmeriHealth Caritas is known as Keystone First in the southeast zone.

Questions Added on December 2, 2019

Q9. If a potential CHC participant calls an Area Agency on Aging (AAA) and needs service, how does the AAA make a referral to a CHC-MCO?

- A. The AAA should refer the participant to the IEB. The IEB, regardless of vendor, will continue to provide enrollment services. Federal rules require that the IEB must be conflict free, and, as such, cannot be a related party to a CHC-MCO or Medicaid provider.

Q10. During the auto-assignment process, are personal assistance service (PAS) providers taken into consideration?

- A. No, the participant's PAS provider is not taken into consideration during the auto-assignment process. In making CHC-MCO assignments, the IEB will use the following hierarchy:
- First, if on the enrollment date the individual is residing in a NF that is a network provider in only one CHC-MCO, the individual will be enrolled in that CHC-MCO;
 - Second, if the individual is enrolled in a dual eligible special needs plan (D-SNP), the individual will be enrolled in the CHC-MCO that is aligned with that D-SNP;
 - Third, if the individual is transferring from HealthChoices (HC) and is a member of a Physical Health HC-MCO that is also a CHC-MCO, the individual will be enrolled in that CHC-MCO; and
 - Last, if the individual's primary care physician (PCP) is a network provider with only one CHC-MCO, the individual will be enrolled in that CHC-MCO.

Participant Eligibility

Q1. Will the annual re-determination still be done and by whom?

- A. As required by federal law, annual redeterminations will still be conducted under CHC. The Department of Human Services' (DHS) independent assessment entity (IAE) will conduct the annual redeterminations of functional eligibility based upon documentation and information which the CHC-MCOs will gather when conducting their comprehensive needs assessments. The county assistance office (CAO) will conduct annual redeterminations of financial eligibility.

Q2. Will prior medical expenses still be considered after CHC implementation?

- A. Medical Assistance (MA) eligibility requirements and rules governing allowable expenses will not change under CHC. The Office of Income Maintenance (OIM) Long-Term Care (LTC) Handbook section 468.3 provides additional information on allowable medical expenses.
<http://services.dpw.state.pa.us/oimpolicymanuals/ltc/index.htm>

Q3. Regarding patient pay, will home maintenance deductions, LTC insurance policies or pharmacy be handled differently under CHC?

- A. No, CHC will not change how home maintenance deductions, LTC insurance policies or pharmacy expenses are applied to patient pay.

Q4. If there is a data mismatch with patient pay, which may be an error with the CAO, how will this be resolved?

- A. The CHC-MCO will receive the patient pay amount from DHS' participant eligibility file. Nursing Facilities (NFs) will continue to collect patient pay and deduct costs for medical services and insurance premiums from the resident's payment toward the cost of NF services. NFs will continue to receive the PA-162 Notice of Eligibility which identifies the patient pay amount. The CHC-MCOs will review the NFs patient pay calculation as submitted on the claim.

NFs should work with the CHC-MCO and CAO to resolve any differences in patient pay. If the CHC -MCO has a question or finds a billing mismatch, the CHC-MCO should contact the NF.

Q5. Will there be a process in place to reconcile differences between the PA-162 and the CHC-MCO's eligibility file?

- A. Providers should work with the CHC-MCO to resolve any differences between the PA-162 and the CHC-MCO's eligibility file.

Q6. Will threshold guidelines change for new MA applicants, the look back period or retroactive eligibility?

- A. MA eligibility requirements will not change under CHC.

Q7. Will retroactive eligibility for NF services continue under CHC?

- A. Yes, a NF resident may be eligible for retroactive MA to cover the cost of NF services. The retroactive period begins as early as the first day of the third calendar month before the application date and ends the day before the application date. If the CAO determines that a NF resident is eligible for MA NF services during all or part of the retroactive period, payment for the NF services will be made as follows:
- If a NF resident who is enrolled in HealthChoices (HC) is determined eligible for MA NF services, the resident’s enrollment in HC will be end-dated and the resident will be enrolled in CHC. The HC-MCO will pay for the resident’s NF services up to and including the date that the resident is determined eligible for MA long-term services and supports (LTSS). Enrollment in a CHC-MCO is effective the day after the eligibility determination and is indicated by the CHC Start Date in the Electronic Verification System (EVS). The HC-MCO will pay for any MA NF services provided during the retroactive period. The CHC-MCO will pay beginning on the CHC Start Date.
 - If a NF resident is not enrolled in HC, MA Fee for Service (FFS) will pay for the MA NF services provided during the retroactive period up to the CHC Start Date. The CHC-MCO will pay beginning on the CHC Start Date.

The NF resident’s PA-162 Notice of Eligibility will specify the date the individual is eligible for payment of MA NF services. The resident’s eligibility effective date, CHC Start Date and HC end-date (if applicable) are also identified in DHS’ Client Information System (CIS). For additional information, see Ma Bulletin 03-18-20, Changes to Managed Care Coverage of Nursing Facility Services, which is available at:

https://www.dhs.pa.gov/docs/Publications/Documents/FORMS%20AND%20PUBS%20MAP/c_283001.pdf

Q8. Will the 180-Day exception rule still exist for retroactive billing during the transition from FFS to CHC?

- A. Yes, to receive FFS payment for NF services provided during the retroactive eligibility period, the NF must comply with the 180-day exception rule in 55 Pa. Code § 1101.68(c) and (d).

Q9. Are CHC recipients subject to estate recovery?

- A. Yes, as required by Federal law, DHS’ Estate Recovery Program recovers MA payments for home and community-based (HCBS), NF and related hospital and prescription drug services provided to individuals who are 55 years and older.

Q10. Considering the number of participant enrollment delays, why doesn't DHS implement presumptive eligibility with the rollout of CHC?

- A. The Commonwealth has decided not to implement presumptive eligibility at this time.

Q11. Will CHC change what services are considered allowable other medical expenses to be deducted from the patient pay amount?

- A. No, CHC will not change the financial eligibility criteria or eligibility process. NFs will continue to collect patient pay and may deduct allowable medical expenses from the resident's payment toward the cost of NF services.

Q12. What happens when the comprehensive assessment determines individual is no longer NF clinically eligible (NFCE)?

- A. If DHS' IAE determines that an individual no longer needs the NF level of care (LOC) (i.e., the individual is NF Ineligible ("NFI")), the individual would no longer be eligible for LTSS. If the individual otherwise qualifies for CHC, the individual will continue to receive physical healthcare from his or her CHC plan.

Q13. For residents who reside in a NF when CHC begins in a zone, what is the criteria that allows these residents to remain in their facility as long as they need this LOC?

- A. CHC participants who reside in a NF when CHC is implemented in the CHC zone will be permitted to continue receiving care at that facility until the participant either leaves the facility or is disenrolled from CHC, or the facility is no longer enrolled as a provider in the MA program.

CHC participants admitted to a NF after the CHC implementation date will receive the standard 60-day COC protections. For additional information regarding the 60-day COC provision, see MA Bulletin 99-03-13 which is available at: <https://www.dhs.pa.gov/docs/For-Providers/Pages/Bulletin-Search.aspx>

Q14. Will participants enroll via electronic and/or paper?

- A. Participants may apply electronically through the Commonwealth of Pennsylvania Access to Social Services (COMPASS) or using the paper PA 600L, Application for Benefits.

Q15. If the resident is approved for MA with a penalty period, does the HC-MCO or CHC-MCO continue to provide service coordination and ensure all required services are provided during the penalty period?

- A. A participant who is in a penalty period will remain in CHC or HC. If the individual requires service coordination, the participant's MCO should assist in coordinating with other insurers such as Medicare and in identifying other entities that can provide service. However, the MCO is not responsible for covering LTC facility services, or HCBS under CHC during the penalty period because the individual is not eligible for payment of LTC facility services or HCBS during the penalty period.

Q16. What is the difference between the CHC LTSS population and the CHC NFI Dual population?

- A. CHC covers two groups of MA participants who are aged 21 and older:
- Participants who need long-term services and supports because they are NFCE; and
 - Participants who are dually eligible for MA and Medicare, whether or not they are NFCE.

Q17. What is the first step for a participant who is interested in receiving LTSS?

- A. If a participant is interested in receiving LTSS, we recommend that the participant contact the Independent Enrollment Broker (IEB) to begin the LTSS eligibility determination process. Participants can also file applications for MA benefits, including LTSS, online using DHS' COMPASS system, which is available at:
<https://www.compass.state.pa.us/Compass.Web/Public/CMPHome>.

Participants can also visit the local CAO to apply in person or download an application from the DHS website and mail it to the local CAO.

Q18. For CHC participants, what is the timeframe from being approved to actually receiving MA services?

- A. CHC participants who are receiving MA services at the time of their enrollment will continue to receive those services during a COC period. Newly eligible CHC participants may begin receiving physical health and NF services as soon as they are enrolled in CHC.

The CAO has 45 days to determine financial eligibility for new applicants applying for payment of LTSS. CHC-MCOs are required to conduct a comprehensive needs assessment and develop a Person-Centered Service Plan (PCSP) for participants who are determined eligible for or are identified as needing LTSS. Newly eligible CHC LTSS participants will begin receiving HCBS once the PCSP is finalized. CHC-MCOs must have policies and procedures to identify and address participants with immediate service needs.

Q19. Revised March 20, 2018 – Question and response moved to Medicare section

Q20. Will participants be able to select from all the CHC-MCOs regardless of where they live?

- A. Yes. AmeriHealth Caritas, Pennsylvania Health and Wellness (Centene) and UPMC Community HealthChoices were selected to provide services on a statewide basis. AmeriHealth Caritas is known as Keystone First in the southeast zone.

Q21. How easy will it be for participants to switch CHC-MCOs? For example, what if my provider enrolls with a different CHC-MCO?

- A. A participant has the right to change his or her CHC-MCO at any time; however, the participant's enrollment in the new plan will take effect depending on when the participant requests the transfer. Generally, if a participant requests to transfer to a new plan during the first half of the month, the participant's enrollment in the new plan will be effective on the first day of the following month. If the participant requests to transfer during the second half of the month, the participant's enrollment in the new plan will be effective on the first day of the second month following the transfer request. For example, if a participant makes a request to transfer to a new plan on March 2, 2018, the participant will be enrolled in the new plan effective April 1, 2018. If the participant makes the request on March 16, 2018, the participant will be enrolled in the new plan effective May 1, 2018.

The CHC-MCO is prohibited from restricting participants from changing CHC-MCOs. Service Coordinators and the IEB will assist participants in facilitating a seamless transition between CHC-MCOs.

Q22. Will providers, including NFs, still be able to send MA applications directly to the CAO or do they have to go through the IEB?

- A. If a provider is a COMPASS Community Partner, the provider may submit MA applications on behalf of an applicant through the COMPASS system. A provider can also assist a participant in completing an application and may submit a hard copy application on behalf of an applicant to the IEB or CAO.

Q23. For the PA-600L form, are paper applications no longer acceptable and must participants use the IEB or COMPASS to file an application?

- A. CHC will not change the current process, both paper and electronic applications will be accepted.

Q24. Does the IEB determine financial eligibility prior to doing the MA-51 and having the IAE complete the LOC determination or can the NF initiate the LOC determination?

- A. The IEB does not determine financial eligibility. The CAO determines financial eligibility. CHC does not change the eligibility criteria or eligibility process. NFs can initiate the LOC themselves through the IAE.

Q25. What is the role of the IEB for a MA NF resident?

- A. During the pre-transition period, the IEB will assist MA NF residents who choose or are required to enroll in CHC to select a CHC-MCO and primary care physician (PCP), and, if the residents do not make a voluntary plan selection, assign those individuals to a CHC-MCO using criteria that align with the way in which the individual currently receives services. Once CHC is implemented, in addition to providing these services, the IEB will also assist NF residents in managing the LTSS application and eligibility process. This includes selecting a CHC-MCO, making referrals to a local Living Independence for the Elderly (LIFE) provider, processing requests to change CHC-MCO plans, providing enrollment materials, assisting CHC participants and assisting LTSS applicants through the MA functional and financial eligibility process, and providing information on nursing home transition.

Q26. During the MA eligibility application process, at what point is CHC and the CHC-MCO options presented?

- A. During the pre-transition period, which occurs before CHC is implemented in a zone, DHS and the IEB will provide both NFI Dual and LTSS participants with information about CHC and their CHC-MCO options so that the participants can select a CHC-MCO before CHC is implemented in the Zone. LTSS participants, aged 55 or older, will also have the opportunity to apply to enroll in a LIFE program. Once CHC is implemented in a zone, NFI Dual participants will be auto-assigned to a CHC-MCO plan when they are determined eligible to participate in CHC. They will receive a post-enrollment packet of information from the IEB that provides information about CHC and explains how the participants can contact the IEB to select a different CHC-MCO. Individuals who apply for or are interested in receiving LTSS after CHC is implemented in a zone will receive a CHC pre-enrollment packet from the IEB at the same time the IEB sends them an LTSS application packet. The CHC pre-enrollment packet will provide information about CHC and the CHC-MCO plan options. The IEB will assist LTSS Applicants to make an advance plan selection before they are enrolled in CHC. LTSS applicants, aged 55 or older, will also have the opportunity to apply to enroll in a LIFE program if LIFE services are available in their service area.

Q27. What is the process if a provider wishes to terminate providing services to a participant?

- A. The CHC-MCOs must develop provider policies, which the DHS must approve, including requests from providers to dismiss participants from the practice through an expedited process.

Q28. What is the most efficient method for a new participant to learn about CHC-MCOs?

- A. Participants should read all of the materials sent to them and attend informational meetings. Participants should also review communication materials on the DHS website:

<http://www.healthchoices.pa.gov/info/about/community/commpart/index.htm>

Q29. Can a CHC-MCO prevent a NF resident from leaving a NF?

- A. If a resident is capable of decision-making or has a representative acting on his/her behalf, neither the CHC-MCO nor the NF can prevent the resident from leaving a NF.

Q30. Who does the initial functional eligibility determination (FED) and subsequent redeterminations and how often? What's the difference between the IEB and the IAE for determining eligibility at the start of services?

- A. The IEB provides choice counseling to CHC participants to assist them in selecting a CHC-MCO and PCP. The IEB also assists long- term services and supports (LTSS) applicants with the LTSS application and eligibility process.

The IEB will collect information from the participant and send an alert to the IAE to complete the initial FED, which DHS uses in determining whether an LTSS applicant is functionally eligible for LTSS.

DHS' IAE will be responsible to complete the initial FED and annual redeterminations of functional eligibility based upon documentation and information which the CHC-MCOs will gather when conducting their comprehensive needs assessments.

Q31. If a participant is on MA, must this individual wait the 2-year waiting period for Social Security Disability/Medicare to be covered by a CHC plan?

- A. No, an MA participant, aged 21 or older, can enroll in CHC if the participant is NFCE and needs LTSS even if he or she has not been determined eligible for Social Security Disability/Medicare benefits.

Q32. Will the PCP have any role in the FED?

- A. The PCP may complete the physician certification for the FED process.

Q33. For individuals who are in a state veteran's home or state hospital and being evaluated for discharge to a NF or HCBS, how will the process change based on implementation of CHC?

- A. Residents of state operated facilities, such as veteran's homes or state LTC units located at state psychiatric hospitals, will not be enrolled in CHC. If a resident of a state operated facility or hospital is transferred to a non-state operated facility, such as a county or private NF, or applies for HCBS, that individual will be enrolled in CHC if he or she is NFCE and financially eligible for MA LTSS.

Q34. Does a provider check participant eligibility with the CHC-MCOs?

- A. Providers must use the electronic EVS to verify participant MA eligibility, CHC-MCO and PCP assignment, Third Party Liability, and scope of benefits.

Questions Added on December 2, 2019

Q35. What if you complete an EVS check and the participant no longer has their benefit? What should you do?

- A. Providers should work with the CHC-MCO to resolve any differences between EVS and the CHC-MCO's eligibility file. The CHC-MCOs are not responsible for any payments to providers for services rendered outside of the participant's eligibility period.

Q36. Can a CHC member get terminated retroactively?

- A. Other than retroactive termination due to death, situations in which CHC eligibility is terminated retroactively should rarely occur as 55 Pa. Code § 133.4(b)(ii) requires DHS to give advance notice to the participant when reducing or closing MA. In addition, 55 Pa. Code § 133.4(3)(ii) requires that there be at least 10 days between issuing the advance notice and proposed action taking place. Participants have the right to appeal; if the participant requests a hearing before the date of the proposed action, DHS may not terminate or reduce services until a decision is rendered after the hearing (42 CFR §431.230 Maintaining Services).

Q37. When terminating a provider, how much notice do the CHC-MCOs have to give to the participant?

- A. The CHC-MCO must give participants at least 45 days advance notice of their provider terminating. The 45 day advance written notice requirement does not apply to terminations by the CHC-MCO for cause.

Q38. Is it possible to get an email when a participant changes CHC-MCO?

- A. EVS is updated daily to reflect the most recent eligibility. A recipient's eligibility is subject to change; therefore, providers should use EVS to verify eligibility each time services are provided to recipients. Please also see Q6 in the Eligibility Verification System (EVS) section of this document.

In addition, for all participants, the CHC-MCO must comply with COC 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. To ensure continuity of services for participants receiving LTSS, CHC-MCOs must obtain the transitioning participants' current PCSP or obtain an electronic record that includes all of the information contained in the current PCSP. CHC-MCOs must contact the providers identified in the service plan from the transferring FFS program or CHC-MCO to confirm continuation of service authorization and payment. The term contact means the CHC-MCO provides an authorization of service that includes the type, scope, amount, duration, and frequency of services to be provided. The CHC-MCO must initiate contact within two business days of the date the CHC-MCO receives the PCSP or electronic record.

Provider Billing

Q1. What are the CHC-MCO billing requirements, timeframes, submission options, and IT requirements?

- A. Each CHC-MCO will establish its provider billing requirements, filing timeframes, and submission options. These topics should be discussed with the CHC-MCOs. CHC-MCOs are required to have provider manuals that include their billing and other filing instructions.

Q2. How will CHC-MCOs adjudicate the coordination of benefits for dual eligible participants who receive services from a non-Medicare provider?

- A. CHC-MCOs will be required to conduct provider training on coordination of benefits and dual eligibility for Medicare and Medicaid and coordination of services for participants who are dual eligible. This topic should be discussed with the CHC-MCOs to learn more about their provider training plan.

Q3. When is the claims testing period going to start?

- A. As part of Readiness Review, the CHC-MCO will be required to successfully test its claims processing system prior to implementation of CHC in a given zone. Test samples will include all types of payments and adjustments that are billed through the Department of Human Services' PROMISe™ claims processing system. Providers should contact the CHC-MCOs to learn more about their testing plans.

Q4. If a nursing facility (NF) has its own bus or van, can transport services be reimbursed?

- A. The CHC agreement specifies that CHC-MCOs must provide non-emergency medical transportation for NF residents and non-medical transportation to nursing facility clinically eligible participants. NFs should discuss reimbursement with the CHC-MCOs as part of their rate negotiation. NFs may not directly bill the CHC-MCO for transportation related reimbursement unless they are enrolled as a transportation provider in the Pennsylvania Medical Assistance (MA) program.

Q5. How will hospice services in a NF be reimbursed under CHC? Will the NF have to bill hospice for the MA residents' room and board or will hospice bill MA?

- A. **Revised May 1, 2018** – After CHC is implemented in a zone, the hospice provider and nursing facility will bill the CHC-MCO for services rendered. The hospice provider will bill the CHC-MCO for any hospice services rendered and NFs will bill the CHC-MCO for the MA residents' room and board. *Please refer to the Medicare section of this document for additional information.*

Q6. Will a Medicare denial be required to be on file for an invoice to be approved and paid?

- A. If the participant has a third-party resource (TPR), including Medicare, that covers a service, providers must bill the TPR first for payment of the covered service and obtain an Explanation of Benefits (EOB) from the TPR. Once the TPR has paid or denied the claim, providers may then bill CHC-MCOs.

Q7. If a provider is not Medicare certified, how will the CHC-MCO handle the services?

- A. CHC-MCOs will be required to develop and implement Person-Centered Service Plans (PCSP) that address how the participant's physical, cognitive and behavioral health needs will be managed, including how Medicare coverage (if the participant is dual eligible) will be coordinated and how the participant's long-term services and supports (LTSS) will be coordinated. CHC-MCOs will be required to train providers on Medicare coordination for dual eligible services.

Q8. What will be the claim payment timeframes? Are there "Prudent payment" policies?

- A. The Department of Human Services (DHS) has established claims payment timeliness requirements for the CHC-MCOs. 90.0% of clean claims must be adjudicated within 30 days of receipt. 100% of clean claims must be adjudicated within 45 days of receipt. 100% of all claims must be adjudicated within 90 days of receipt. If DHS determines that a CHC-MCO has not complied with the claims processing timeliness standards, DHS may impose sanctions on the CHC-MCO. Providers should discuss claims submission and expected payment timeframes with the CHC-MCOs.

Q9. Will providers have to use three different CHC-MCO billing systems?

- A. Each CHC-MCO will have its own billing system. The CHC-MCOs must demonstrate to DHS that their systems work. CHC-MCOs will be testing their billing systems and will seek provider volunteers to participate in the testing.

Q10. Who do providers contact if they have problems with payment from CHC-MCOs?

- A. Providers must bill the appropriate CHC-MCO to receive reimbursement for services provided after the implementation of CHC in each zone. Services provided prior to CHC implementation must be billed to DHS via PROMISE™ for reimbursement. Each CHC-MCO will have its own billing system. CHC-MCOs are required to train providers on claims submission, any electronic visit verification system and other software systems such as their service coordination system. Providers should contact the CHC-MCO if they are having problems receiving payment on their claims. CHC-MCOs must have a provider dispute resolution process to resolve provider disputes and appeals.

Q11. Revised March 20, 2018 – Question and response moved to the Medicare section of this document.

Q12. Revised March 20, 2018 – Question and response moved to the Medicare section of this document.

Q13. How can a provider check whether a CHC participant has Medicare or other supplemental insurance coverage?

- A. Providers are required to check the Eligibility Verification System (EVS) to ensure a participant is eligible for services prior to rendering services. EVS will identify the participant's CHC-MCO and will identify any third-party resource (TPR) information, including Medicare. At the date of service, providers should always ask participants for all forms of insurance, not just their CHC-MCO insurance card or ACCESS card. This is to ensure that benefits are properly coordinated and that the CHC-MCO remains the payer of last resort.

Q14. Why can't providers use PROMiSe™ to bill the CHC-MCOs?

- A. Providers must bill the appropriate CHC-MCO to receive reimbursement for services after the implementation of CHC in each zone. Each CHC-MCO will have a billing/claims system. CHC-MCOs are required to train providers on claims submission, electronic visit verification systems, and other software systems such as the service coordination system, as well as many other aspects of CHC.

Q15. What is the billing procedure and how can providers test the claims process?

- A. Each CHC-MCO will have its own billing/claims system. The CHC-MCOs are required to demonstrate to DHS that their billing system works. CHC-MCOs will be testing their billing systems and will seek provider volunteers to participate in the testing. CHC-MCOs are required to train providers on claims submission, electronic visit verification systems, and other software systems such as service coordination system. Providers must bill the appropriate CHC-MCO to receive reimbursement for services provided after the implementation of CHC in each zone.

Q16. How will NFs be reimbursed for newly eligible CHC participants?

- A. Newly eligible NF residents will be enrolled in CHC with an effective date of the day after the eligibility determination date. The CHC-MCO will begin paying for NF services provided on and after the residents' CHC enrollment date.

Newly eligible NF residents may also be eligible for retroactive MA coverage of their NF services prior to their enrollment in CHC. NFs will be reimbursed for services provided to newly eligible participants during this retroactive period as they are today through the fee-for-service delivery system.

Current physical HealthChoices (HC) participants who apply and are approved for Long-Term Care eligibility will remain in the HC-MCO after the initial 30 days of nursing facility coverage until they have been determined eligible for MA-funded LTSS, and enrollment in a CHC-MCO is indicated in EVS. In this case, the HC-MCO would also be responsible for the NF charges from day 31 through the day of the eligibility determination.

Q17. Will the patient liability be paid by the claim or per the EVS system?

- A. The CHC-MCO will receive the patient pay amount from the eligibility file. NFs will continue to collect patient pay and continue to deduct costs for medical services and insurance premiums from the resident's payment toward the cost of NF services. NFs will continue to receive the Pennsylvania Medicaid Long Term Care Application or PA-600L. The CHC-MCOs will review the NF patient pay calculation as submitted on the claim.

Q18. Will the CHC-MCOs still use Myers and Stauffer for nursing facility assessment submissions?

- A. DHS will continue to use the existing Pennsylvania nursing facility assessment system which allows NFs to submit necessary patient days and DHS to obtain the assessment amount that is due.

Q19. What service location is OBRA in PROMISe™?

- A. The OBRA program waiver code in PROMISe™ is WAV09. Providers need to review their provider profile in PROMISe™ to determine which service location is associated with the OBRA waiver.

Q20. What are the criteria for a clean claim?

- A. A clean claim is a claim that can be processed without obtaining additional information from the provider or from a third party, including a claim with errors originating in the CHC-MCO's claims system. Claims under investigation for fraud or abuse or under review to determine if they are medically necessary are not clean claims.

Q21. Define "adjudicated claim."

- A. An adjudicated claim is a claim that has been processed for payment or denial.

Q22. Will EVS reflect the participant's current CHC-MCO selection?

- A. EVS methods, inquiry and response formats will not change with CHC implementation. EVS will display the participant's CHC-MCO plan code information and PCP if available. All other existing waiver benefit packages and HealthChoices managed care responses remain unchanged. Please reference Provider Quick Tip #11 for more information related to EVS.

[https://www.dhs.pa.gov/providers/Quick-Tips/Documents/11%20-%20The%20Eligibility%20Verification%20System%20\(EVS\).pdf](https://www.dhs.pa.gov/providers/Quick-Tips/Documents/11%20-%20The%20Eligibility%20Verification%20System%20(EVS).pdf)

Q23. Will providers use PROMISe™ after CHC implementation?

- A. Providers must submit claims for services provided prior to CHC implementation to DHS via PROMISe™ for reimbursement. Providers must bill the appropriate CHC-MCO to receive reimbursement for services provided after the implementation of CHC in each zone except that: (1) providers will continue to use PROMISe™ for ACT 150 and OBRA waiver participants and (2) NF providers will continue to bill PROMISe™ for NF services provided during the retroactive eligibility period for NF residents. *Please refer to Q15 for additional information.*

Q24. Will providers use the Home and Community Services Information System (HCSIS) after CHC implementation?

- A. After the CHC implementation, providers will only use HCSIS for ACT 150 and OBRA waiver participants. *Please refer to Q30 for additional information.*

Q25. If a NF believes that a resident with Medicare is eligible for CHC, what should the facility do?

- A. The NF should contact the Independent Assessment Entity (IAE) to initiate the level of care determination.

Q26. How long will providers have to finish billing for services provided prior to the implementation of CHC?

- A. Providers must submit claims for services rendered to participants in CHC prior to the implementation of CHC following the current timely filing requirements.

Q27. Will changes be made to place of service codes, (e.g. NFs) for the delivery of behavioral health services?

- A. There are currently no plans to change place of service codes in PROMISE™.

Q28. Will individuals with third party behavioral health coverage need to be coordinated with the Behavioral Health MCOs (BH-MCO)?

- A. CHC participants with another non-Medicaid insurance including Medicare, must exhaust behavioral health benefits available under that coverage before BH-MCOs cover services.

Q29. Are high cost medications such as HIV medications covered and how are they billed?

- A. Coverage of prescription drugs will remain the same after CHC implementation. Coverage under Medicare, if available, must be exhausted before CHC-MCOs cover prescriptions.

Questions Added on December 8, 2017

Q30. Can providers and CHC-MCOs continue to use HCSIS and Social Assistance Management Software (SAMS) after the CHC transition period?

- A. CHC-MCOs will have their own systems and will not be required to use HCSIS and SAMS. Providers should consult with CHC-MCOs regarding the systems and procedures that will be used to authorize services.

Q31. How do NFs bill for in-facility respite?

- A. NFs must bill the CHC-MCO for in-facility respite services and should contact the CHC-MCO for more information regarding the CHC-MCO's billing process.

Q32. Revised March 20, 2018 – Question and response moved to the Medicare section of this document.

Questions Added on December 2, 2019

Q33. If a participant's authorization for service has ended and the agency still provides services per the service coordinator (SC), is the agency able to bill for the gap of time after the authorization is updated?

- A. Providers should contact the CHC-MCO for written verification of the service authorization.

Q34. Do all three CHC-MCOs use Change Healthcare as a billing clearing house in addition to using HHAeXchange?

- A. The CHC-MCOs will accept claims from multiple clearinghouses. Providers need to contact their billing clearing house to provide the correct CHC-MCO payer ID for claims transmission.

Q35. How do providers bill for overtime?

- A. Please see Q12 and Q13 in the Provider Rates section of this document.

Q36. Can Physical Therapy, Occupational Therapy, and Speech Therapy be billed at same time as Personal Assistance Services (PAS)?

- A. There are times when Physical Therapy, Occupational Therapy and Speech and Language services may be provided simultaneously with PAS. Services are limited to the participant's needs which are determined during the comprehensive needs assessment and identified in the participant's PCSP. Providers should discuss the simultaneous provision of services and the CHC-MCO's billing process with each CHC-MCO.

Q37. Does billing / services stop at admission to the hospital or entrance to the ER?

- A. Providers may not bill for services rendered to a participant once the participant has been admitted to a hospital, NF or other institutional setting. Providers should contact the CHC-MCO for more information regarding the CHC-MCO's billing policies and processes.

Q38. How does a DME company handle or bill rental equipment when a participant moves from one CHC-MCO to another? Example: 13-month rental CPAP - month 1 through UPMC month 2 through PA Health and Wellness.

- A. A participant has the right to change his or her CHC-MCO at any time; however, the participant's enrollment in the new plan will take effect depending on when the participant requests the transfer based upon the dating rules. Providers should check EVS to identify the participant's CHC-MCO to ensure the appropriate CHC-MCO is billed to receive reimbursement for services provided. *Please refer to EVS Q6 and Provider Billing Q10 for additional information.*

Q39. Are providers required to use HHAeXchange?

- A. The use of HHAeXchange is at each CHC-MCO's discretion. Providers should contact the CHC-MCO for more information regarding HHAeXchange and the CHC-MCO's billing process.

Q40. Will the data from an EVV device automatically import clock in and clock out times to HHAeXchange for ease of billing?

- A. Please see Q5 in the Electronic Visit Verification System (EVV) section of this document for additional information.

Q41. Who will upload the service authorizations to HHAeXchange?

- A. The CHC-MCOs are responsible for uploading authorizations to their systems and HHAeXchange prior to each go-live date and throughout the program.

Q42. Is there anything providers can do to help expedite the process of correcting the demographic information of the participant listed in HHAeXchange?

- A. The provider should refer the participant to the CHC-MCO or to their local County Assistance Office to verify their demographic information.

Q43. When a participant changes CHC-MCOs, does HHAeXchange create a new participant or just show a change in payer source?

- A. When a participant transitions from one CHC-MCO to another, HHAeXchange will create a new participant record for the receiving MCO. The participant's record for the transferring MCO will continue to show in HHAeXchange; providers will see the participant twice in HHAeXchange – one showing as active and one showing as discharged. This allows providers to submit a late claim or make a claims adjustment after the participant has transitioned to a new MCO. The claim or adjustment needs to be submitted to the appropriate MCO for the appropriate dates of service.

Q44. If our organization provides Residential Habilitation Services as well as physical therapy and occupational therapy, do we need access to both the homecare and non-homecare portal of HHAeXchange?

- A. Providers should contact the CHC-MCO for more information regarding HHAeXchange and the CHC-MCO's billing process.

Q45. After the SC submits a participant's paperwork to the CHC-MCO, how long does it take to show up in HHAeXchange?

- A. 24-48 hours is the standard turn-around time. When times exceed this, the provider should communicate to the CHC-MCO through a note in HHAeXchange so that the CHC-MCO can take the appropriate follow-up action to address root cause and ensure that authorizations are transmitted timely.

Q46. During the southwest (SW) CHC implementation, timely filing of claims became an issue (consumers not loaded to HHAExchange, participants deemed ineligible by CAO, etc.) Has this been fixed with the southeast (SE) zone or will this be a possible issue for this roll-out?

- A. In the SE rollout, providers reviewed their participants in HHAExchange at the beginning of CHC launch so that any corrections were made before billing. This process will be used for the Phase 3 implementation.

Q47. Type, scope, amount, duration, and frequency currently do not show up on the HHAExchange authorizations. Will this be updated / upgraded?

- A. The CHC-MCOs are required to communicate the type, scope, amount, duration and frequency to providers. The method of communication is at the discretion of each CHC-MCO, so providers should contact the CHC-MCOs to discuss how type, scope, amount, duration and frequency of services will be communicated.

Q48. Can a provider begin providing services once the SC has approved the participant's service hours, even if the authorization hasn't been uploaded to HHAExchange?

- A. During the continuity of care period (COC), (6-month transfer from FFS or 60 days after switching CHC-MCOs), providers should continue to provide service even if an authorization has not populated in HHAExchange. The provider should also communicate with the MCO by calling or through HHAExchange member-specific notes so that the MCO can address the root cause of the issue and obtain written authorization. After COC, a provider should ensure that they have an authorization before providing service to ensure service provision is consistent with the PCSP and to ensure timely billing and claims.

Q49. Will providers be paid for services if services are not completed?

- A. Providers cannot be paid for services that are not delivered. Providers may bill for the units of service that are provided. For example, if a provider is supposed to provide 4 hours (16 units) of service to Mrs. Smith but is only able to provide 2 hours (8 units) of service, the provider may only bill for the 8 units of service that were provided.

Q50. When a participant changes from one CHC-MCO to another, how long does this process take and will the provider continue to get paid?

- A. Generally, if a participant requests to transfer to a new plan during the first half of the month, the participant's enrollment in the new plan will be effective on the first day of the following month. If the participant requests to transfer during the second half of the month, the participant's enrollment in the new plan will be effective on the first day of the second month following the transfer request. For example, if a participant makes a request to transfer to a new plan on March 2, 2019, the participant will be enrolled in the new plan effective April 1, 2019. If the participant makes the request on March 16, 2019, the participant will be enrolled in the new plan effective May 1, 2019. The surrendering and gaining CHC-MCOs are each responsible for payment of services during the time the participant is enrolled with the MCO.

Q51. Can two providers provide service to one client if an agency can't provide all the hours, can a second agency work on the client?

- A. Participants may continue to use multiple home care agencies to cover the service hours as outlined in their PCSPs. The participant's SC is responsible for communicating the participant's needs and scheduling with each provider to ensure non-duplication of services and shifts.

Q52. Will overlapping shifts be approved for participants who require more than one caregiver at a time?

- A. Providers should discuss these circumstances with the CHC-MCOs.

Q53. Who is responsible for entering activities of daily living (ADL) and instrumental activities of daily living (IADL) information into HHAExchange?

- A. The CHC-MCOs are required to communicate the type, scope, amount, duration and frequency to providers which includes a participant's ADLs and IADLs. The method of communication is at the discretion of each CHC-MCO, so providers should contact the CHC-MCOs to discuss how type, scope, amount, duration and frequency of services will be communicated.

Q54. Can a direct care worker (DCW) be reimbursed by CHC for transportation costs when they use their own vehicle to transport a CHC participant?

- A. DCWs must utilize a third-party transportation vendor for non-emergency medical transportation (NEMT) and non-medical transportation whenever possible. The Medical Assistance Transportation Program (MATP) allows for NEMT mileage reimbursement to a volunteer driver. SCs should contact the participant's local MATP office to inquire about mileage reimbursement. SCs should contact the CHC-MCOs to inquire about the availability of mileage reimbursement through the CHC-MCO's transportation broker for NEMT and non-medical transportation.

If a third-party vendor isn't available to provide NEMT, the DCW may provide NEMT and have it billed and paid as personal assistance services (PAS) time. The SC must clearly document in the service plan the specific reason why a third-party is not available to meet the participant's NEMT needs and/or the specific reason why the third-party option will not work for the participant.

No transportation costs, such as mileage reimbursement, can be covered in addition to PAS when PAS is being used to provide transportation and accompany the participant.

Q55. Can a DCW be reimbursed by CHC when paying out of pocket to travel on the bus with a CHC participant who has a bus pass?

- A. MATP allows for a medically necessary escort to accompany a participant at no extra cost. This is an option for DCWs who need to accompany a participant on the bus. SCs should contact the CHC-MCOs to inquire about the CHC-MCO transportation broker's policy on escorting a participant who travels by bus.

If MATP or the CHC-MCO's transportation broker cannot pay for the transportation, DCWs may bill and be paid for PAS as long as direct care tasks are needed during transportation provided by a third-party vendor, such as taxi rides or bus trips, and no duplicative direct care tasks are being completed by the third-party vendor.

Provider Disputes

Q1. What can a provider do if they disagree with a CHC-MCO's decision, especially if the CHC-MCO decides to terminate the provider from the network?

- A. The CHC-MCO must develop, implement, and maintain a provider dispute resolution process, which provides for informal resolution of provider disputes at the lowest level and a formal process for provider appeals. The CHC-MCO and the provider must handle the resolution of all issues regarding the interpretation of provider agreements and shall not involve the Department of Human Services (DHS); therefore, provider disputes and appeals are not within the jurisdiction of the DHS's Bureau of Hearings and Appeals.

Q2. Is there anything that can be done when CHC-MCOs close contracting or decide not to contract with a provider?

- A. Providers may appeal the denial of credentialing or termination of their provider agreements to the CHC-MCOs. The CHC-MCO must develop, implement, and maintain a provider dispute resolution process, which provides for informal resolution of provider disputes at the lowest level and a formal process for provider appeals. Each CHC-MCO must establish a Provider Appeal Committee, which providers can use to appeal the decision to deny credentialing or termination of a provider agreement. At least 25% of the membership of the committee must be comprised of providers/peers. This process does not involve the Department of Human Services (DHS); therefore, provider appeals are not within the jurisdiction of the DHS' Bureau of Hearings and Appeals. The CHC-MCOs are contractually required to notify DHS of any intent to terminate with a network provider. MCOs are also required to submit termination notifications to participants.

Q3. Can the provider appeal a CHC-MCO decision?

- A. A provider can file a provider dispute with the CHC-MCO to express dissatisfaction with a decision that directly impacts the provider (excluding decisions concerning medical necessity). A provider can file an appeal with the CHC-MCO to dispute the CHC-MCO's decision to deny the provider credentialing, deny the provider's claim or termination of the provider's provider agreement. Each CHC-MCO must establish a Provider Appeal Committee to hear and process provider appeals. At least 25% of the membership of the committee must be comprised of providers/peers.

Q4. Is the 25% of Provider Appeal Committee made up of CHC-MCO providers or can Medicare only providers, such as D-SNP providers, be used to meet the requirement?

- A. The CHC-MCO agreement requires that providers/peers must account for at least 25% of the Provider Appeal Committee membership. This could include CHC-MCO providers who are enrolled in both Medicaid and Medicare and/or providers solely enrolled in Medicaid.

Q5. Is there a special review of provider appeals that did not have 75% of the votes?

- A. The CHC-MCOs must submit and the Department of Human Services (DHS) must approve the CHC-MCOs Provider Dispute and Appeal Process. This will include how the CHC-MCO is proposing to handle voting on appeals. DHS will review reports from the CHC-MCOs on provider appeal decisions to determine if CHC-MCOs are administering the process in accordance with the CHC agreement. Any specific questions about the provider dispute process, including voting criteria, should be discussed with the CHC-MCOs.

Q6. How does a provider get on the provider appeals committee?

- A. Providers should contact the CHC-MCOs to learn about participating on the Provider Appeal Committee.

Q7. What role will the Department of Human Services (DHS) play for provider disputes and appeals?

- A. The Department of Human Services will review and approve the CHC-MCOs policies and procedures for resolution of provider disputes and appeals. DHS will also review reports from the CHC-MCOs on provider appeal decisions. The CHC-MCO and the provider must handle the resolution of all issues relating to provider disputes and provider appeals. This process does not involve DHS and provider appeals are not within the jurisdiction of DHS's Bureau of Hearings and Appeals.

Provider Education

Q1. Will CHC-MCOs train providers on their claims and billing systems?

- A. The CHC-MCOs are required to train providers on claims submission. Per the CHC Agreement, each CHC-MCO must have a Provider Claims Educator who is located in Pennsylvania and facilitates the exchange of information between grievances, claims processing, and provider relations systems. This includes educating contracted and non-contracted providers on appropriate claims submission requirements, coding updates, electronic claims transaction and electronic fund transfer, and available CHC-MCO resources such as provider manuals, websites, fee schedules, etc.

Q2. Are there tentative dates for the CHC-MCOs to provide training? Will CHC-MCOs have standing sessions such as Third Thursday CHC webinars to help educate providers?

- A. The CHC-MCOs are required to train providers on all aspects of CHC prior to the implementation of each zone. Providers should contact the CHC-MCOs to learn about CHC-MCO specific educational opportunities. Regarding the Third Thursday webinars, the Office of Long-Term Living plans to continue hosting these webinars throughout the implementation phases of CHC.

Q3. When will provider manuals be available?

- A. The CHC-MCOs must develop and maintain a provider manual to inform network providers of each plan's administrative procedures and contractual requirements and distribute them in a way that makes them easily accessible to all network providers. The CHC-MCOs must submit their provider manuals to the Department of Human Services (DHS) for review and approval annually and prior to implementation of each CHC zone. Providers should contact the CHC-MCOs to learn when provider manuals will be available and how to access them.

Q4. Will provider manuals be standardized to avoid confusion for providers?

- A. The provider manual needs to accurately reflect the administrative procedures and contractual requirements of each plan. As a result, they cannot be standardized.

Q5. Will there be a companion guide for each CHC-MCO for Electronic Data Interchange (EDI) transactions?

- A. CHC-MCOs are required to train providers on claims submission requirements, coding updates, electronic claims transaction and electronic fund transfer, and available CHC-MCO resources such as provider manuals, websites, and fee schedules. Providers should contact the CHC-MCOs to learn about training and available resources related to EDI transactions.

Q6. Will there be an event where providers can interact directly with the CHC-MCOs?

- A. Yes, provider/CHC-MCO events were held in each zone prior to the implementation of CHC in that zone. Additional information can be found on the CHC website:
<http://www.healthchoices.pa.gov/providers/about/community/index.htm>

Q7. What is the process for a provider to submit questions and claims?

- A. CHC questions may be submitted to the CHC Provider Call Center at 1-833-735-4417, CHC Participant Call Center at 1-833-735-4416 and by emailing RA-PWCHC@pa.gov. For billing related or contracting questions, providers should contact the CHC-MCO.

Q8. How is a copy of the Third Thursday or Managed Long-Term Service and Supports (MLTSS) Sub Committee transcript for the sessions including questions and answers obtained?

- A. Copies of the Third Thursday webinar materials can be found on the CHC website at the following link: <http://www.healthchoices.pa.gov/providers/resources/publications/community/third-thursday-webinars/index.htm>

Likewise, materials from and transcripts of the monthly MLTSS meetings can be found at:
<http://www.dhs.pa.gov/communitypartners/informationforadvocatesandstakeholders/mltss/>

Q9. Will CHC-MCO Provider Relations be available Monday through Friday for billing questions?

- A. CHC-MCOs are required to operate provider service functions, at a minimum, during regular business hours (9:00 a.m. to 5:00 p.m., Monday through Friday). Providers should contact the CHC-MCOs for specific provider service hours.

Q10. What is the CHC-MCO's required ratio for provider relations staff to providers? Is it one account manager to 100 providers?

- A. The CHC-MCOs are required to have sufficient staff in CHC-MCO Provider Services, or equivalent department staff to promptly resolve provider disputes, problems or inquiries. Providers should contact the CHC-MCOs to ask about their specific staffing ratios.

Q11. How will the service coordinators (SC) be trained in areas such as Medicare or services available through behavioral health MCOs?

- A. The CHC-MCO must develop and maintain a provider network that is knowledgeable and experienced in treating and supporting participants in CHC. This includes training SCs on topics such as Medicare and behavioral health services so they can effectively coordinate services for participants who are dually eligible for Medicare and Medicaid and for participants receiving services through the Behavioral Health MCOs.

Questions Added on December 2, 2019

Q12. Do we (service providers) have to attend three different MCO's training? Could they collaboratively do the trainings together?

- A. The CHC-MCOs are required to train providers on all aspects of CHC prior to the implementation of each zone. This includes educating contracted and non-contracted providers on appropriate claims submission requirements, coding updates, electronic claims transaction and electronic fund transfer, and available CHC-MCO resources such as provider manuals, websites, fee schedules, etc. While the CHC-MCOs initially conducted some collaborative training for SCs, provider training needs to accurately reflect the administrative procedures and contractual requirements of each plan. As a result, not all trainings can be done collaboratively.

Q13. Where can we get information for all CHC-MCO and HHAeXchange trainings?

- A. Providers should contact the CHC-MCOs to learn about all available trainings and resources.

Provider Enrollment

Q1. What are CHC-MCO contractual requirements, length of contracts, and performance expectations? How will the CHC-MCOs select providers?

- A. Providers should discuss contracting requirements, selection criteria, and performance metrics with the CHC-MCOs.

Q2. Will CHC-MCO representatives visit nursing facilities (NF) prior to signing contracts?

- A. NFs should contact the CHC-MCOs to request how the CHC-MCOs will approach contracting.

Q3. Is there/will there be an opportunity for individual providers to present available services to service coordinators?

- A. Providers should contact the CHC-MCOs to discuss the services they provide.

Q4. What happens if a provider is already contracted with UPMC and AmeriHealth? Is another contract necessary?

- A. Providers should contact the CHC-MCOs to discuss how they will include CHC in current contracts.

Q5. Can you describe accreditation standards for home health and home care? Will there be any special accreditation such as Joint Commission on Accreditation of Healthcare Organizations (JCAHO)?

- A. Providers should contact the CHC-MCOs to discuss credentialing or other types of requirements such as JCAHO.

Q6. Will CHC-MCOs have the same regulations for providers?

- A. The CHC-MCOs must comply with all state and federal licensing requirements. However, CHC-MCOs may establish additional criteria to ensure quality. Providers should discuss requirements with the CHC-MCOs.

Q7. Will durable medical equipment be contracted separately with each CHC-MCO?

- A. All providers who want to provide services to CHC participants must contract with CHC-MCOs. Providers should contact the CHC-MCOs to discuss contracting.

Q8. Will CHC-MCOs all have their own credentialing?

- A. CHC-MCOs are required to have a credentialing process and must establish and maintain minimum credentialing and re-credentialing criteria for all provider types that satisfy the Department of Human Services' (DHS) requirements outlined in the CHC Agreement.

Q9. If my agency is already approved and enrolled through the PA Medical Assistance (MA) Program, does my agency also need to go through credentialing with the CHC-MCOs? Will the provider revalidation process through the Office of Long-Term Living (OLTL) continue?

- A. All CHC-MCO providers must be enrolled in the PA MA Program and must be credentialed by and contracted with a CHC-MCO to receive reimbursement for a CHC participant. The MA enrollment process verifies a provider meets MA enrollment requirements. This process as well as provider revalidation through OLTL will continue. Providers must be enrolled in the MA program for all types of services they wish to provide under CHC.

Apart from the MA provider enrollment process, CHC-MCOs must establish their own provider credentialing process to meet necessary CHC-MCO accreditation standards. This credentialing process must meet requirements related to the approval process, how long information can be used in verifying providers, and direct verification of provider information.

Q10. As a provider contracted for multiple waivers, what do I need to do for CHC?

- A. Providers may contact CHC-MCOs to discuss contracting; participate in the CHC Third Thursday webinars to learn more about CHC; participate in stakeholder engagements; read and share within your organization any CHC-related information sent to you by DHS; and, participate in upcoming educational sessions hosted by DHS.

Q11. If a provider currently serves only one waiver program, will this be a disadvantage when the CHC program rolls out?

- A. Providers should make a business decision on which waivers and programs they wish to operate. Providers interested in serving participants in the CHC waiver should contact the CHC-MCOs to discuss contracting.

Q12. Will providers be selected to participate with all CHC-MCOs or just one or two?

- A. Providers may choose to contract with some or all of the CHC-MCOs. Providers should contact the CHC-MCO to discuss contracting. Providers must agree to contractual terms and meet CHC-MCO participation requirements.

Q13. If the providers get through provider enrollment and credentialing, shouldn't they be guaranteed a contract from the CHC-MCO beyond the 180 days? Doesn't that indicate that the provider has met the quality standards?

- A. Provider enrollment and credentialing establish that a provider meets minimum qualifications to participate in the program. Contracting generally involves rate negotiation and review-of-quality measures. The continuity of care (COC) period is a provider's opportunity to demonstrate the ability to deliver high-quality services.

Q14. What criteria will CHC-MCOs use to reduce their networks after the COC period? Won't CHC-MCOs just want to contract with large providers?

- A. CHC-MCOs must maintain an adequate provider network. The CHC-MCOs will have their own criteria for measuring provider performance. Providers may want to request this information from the CHC-MCO during the contracting process.

Questions Added on December 2, 2019

Q15. What are the set criteria for credentialing and enrolling with MCOs?

- A. Please see Q9 in the Provider Enrollment section of this document.

Q16. How important is it for providers to obtain accreditation?

- A. Providers should contact the CHC-MCOs to discuss credentialing or other types of requirements.

Q18. Are providers required to contract and credential with each CHC-MCO for each zone?

- A. Providers should contact each CHC-MCO to discuss their contracting and credentialing requirements across CHC zones.

Q19. What extra steps must an agency take if we add services and/or counties?

- A. Providers wishing to add services or counties to their provider profile should contact the OLTL Provider Call Center at 1-800-932-0939 and select Option 1 or send an email to RA-HCBSEnProv@pa.gov

Q20. After CHC how will providers maintain office address updates and opening of new offices?

- A. Providers wishing to update office addresses or new offices on their provider profile should contact the OLTL Provider Call Center at 1-800-932-0939 and select Option 1 or send an email to RA-HCBSEnProv@pa.gov

Q21. I'm a DME provider. We've received different answers from the 3 CHC MCOs in regard to the provider type. Must a DME provider be both provider type 25 and 59?

- A. All CHC-MCO providers must be enrolled in the PA MA Program and must be credentialed by and contracted with a CHC-MCO to receive reimbursement for a CHC participant. A DMEPOS provider must be enrolled as provider type 25 to provide services and products to CHC participants through the Medicaid State Plan. DMEPOS providers who are interested in providing products to participants who are receiving LTSS services through the CHC home and community-based waiver must be enrolled directly as MA providers with OLTL as provider type 59.

Q22. What is the enrollment process for personal assistance services (PAS) providers – How long does the process take and who do we contact?

- A. All CHC-MCO providers must be enrolled in the PA MA Program and must be credentialed by and contracted with a CHC-MCO to receive reimbursement for a CHC participant. Providers should contact the OLTL Provider Call Center at 1-800-932-0939, Option 1, or send an email to RA-HCBSEnProv@pa.gov with questions pertaining to the initial provider enrollment process.

Apart from the MA provider enrollment process, CHC-MCOs must establish their own provider credentialing process to meet necessary CHC-MCO accreditation standards. This credentialing process must meet requirements related to the approval process, how long information can be used in verifying providers, and direct verification of provider information.

Provider Rates

Q1. Is the CHC-MCO per member per month (PMPM) rate public information?

- A. The fully executed CHC agreements are available on the CHC website, however the rate information will be redacted. The agreements can be viewed at the following link:
<http://www.healthchoices.pa.gov/providers/resources/publications/community/supporting-documents/index.htm>

Q2. Will providers all be paid the same rate by all CHC-MCOs or is the rate up to each CHC-MCO?

- A. CHC-MCOs determine their rates. The Department of Human Services (DHS) is requiring an extended continuity-of-care provision for personal assistance and nursing facility services to promote quality of care and quality of life for participants. The CHC-MCOs must develop a rate configuration that assures that the extended continuity of care period condition will be met and that assures access, quality of life and quality of care.

Q3. Will there be any provisions in the contract that will allow for renegotiation of rates in the event that major legislation is passed to increase the minimum wage?

- A. The CHC Agreement permits adjustments to the CHC-MCOs capitation rates if the Department of Human Services (DHS) determines that a change in the scope of eligible individuals or services, inclusive of limitations on those services that are the responsibility of the CHC-MCO, requires an adjustment to maintain actuarially sound rates. CHC-MCOs and providers may include provisions in their contracts specifying when payment rates may be renegotiated. In addition, a CHC-MCO must demonstrate to DHS that its nursing facility (NF) payment rates have accounted for increased NF costs as a result of any mandates on staffing, wages, and related cost drivers that are imposed after the implementation date.

Q4. Do the CHC-MCOs determine the provider rates?

- A. CHC-MCOs may negotiate rates with providers unless otherwise noted in the CHC Agreement. The capitation rates provide sufficient funds that allow the CHC-MCOs to negotiate rates, on average, that are equivalent to the Fee-for-Service (FFS) rates. The CHC-MCOs and the Department of Human Services (DHS) have agreed upon payment provisions to address the risk of high cost participants. DHS is requiring an extended continuity of care provision for personal assistance services and nursing facility services to promote quality of life and quality of care. The CHC-MCOs must develop a rate configuration that assures access, quality of life and quality of care.

Q5. How do providers continue to serve clients if the CHC-MCOs lower the rates?

- A. CHC-MCOs must maintain an adequate provider network and will be subject to ongoing monitoring by the Department of Human Services (DHS). CHC-MCOs and providers need to work together to ensure that negotiated rates will enable the providers to provide quality services to participants. For certain services, CHC-MCOs must develop a rate configuration that assures access, quality of life and quality of care.

Q6. Are provider rates increased if a provider is asked to do more?

- A. This should be a topic discussed with the CHC-MCOs as part of contract discussions.

Q7. Will there be a minimum or maximum reimbursement rate set for providers throughout the state? Will the state help determine what these rates will be?

- A. CHC-MCOs will negotiate reimbursement rates with providers. The CHC-MCOs may negotiate with providers to perform specialized services. The CHC-MCO may have regional rate variations. The Department of Human Services (DHS) will not be involved in the negotiations.

Q8. Will the rates set in the initial contract continue after the continuity period or will they be renegotiated?

- A. Providers should contact the CHC-MCOs to discuss reimbursement rates as part of the contracting process.

Q9. What incentive is there for the CHC-MCO to offer a rate to one provider as opposed to another provider?

- A. CHC-MCOs may consider items such as preventable hospital admissions and quality outcomes in contracting with providers. Providers should contact the CHC-MCOs to discuss reimbursement, incentives and contracting.

Q10. How would the reimbursement rate for providers be any different under the current system as opposed to when CHC-MCOs take over? And when will CHC-MCOs discuss rates with providers?

- A. Under CHC, the CHC-MCOs will negotiate rates with providers. Providers should contact the CHC-MCOs to discuss rates, the process, and timing.

Q11. Service coordinators track billable time in 15-minute units. During the continuity of care period, will service coordinators need to continue to bill by unit or will reimbursement be per member per month (PMPM)?

- A. Service coordinators should contact the CHC-MCOs to discuss billing requirements and reimbursement methodology under CHC.

Q12. What are the personal assistant services rates for overtime, holiday, travel time and no show when participant is not home?

- A. Providers should contact the CHC-MCOs to discuss provider reimbursement rates for these services.

Q13. Will the CHC-MCOs be paying agencies for overtime, holiday pay or mileage when transporting a participant?

- A. The CHC-MCOs are required to comply with state and federal regulations. Providers should contact the CHC-MCOs to discuss reimbursement for these items.

Q14. How much per unit for home care services?

- A. Under CHC, the CHC-MCOs will negotiate rates with providers. Providers should contact the CHC-MCOs to discuss rates.

Q15. When will a nursing facility rate methodology be established?

- A. The Department of Human Services (DHS) emailed a list serve message on July 10, 2017, that describes DHS' expectations on how CHC-MCOs must reimburse nursing facilities for the first 36 months in which CHC is operational. The CHC-MCOs will need to develop a rate configuration to meet this requirement. This email message can be viewed at:

<http://listserv.dpw.state.pa.us/Scripts/wa.exe?A2=ind1707b&L=otl-nursing-facilities&F=&S=&P=95>

Nursing facilities should contact the CHC-MCOs to discuss rates.

Q16. Will there be the opportunity to request a higher level of nursing home payment for any unique circumstances or more complex residents? And if so, will it require a prior authorization?

- A. Under CHC, the CHC-MCOs will negotiate rates with providers. Providers should contact the CHC-MCOs to discuss rates and prior authorization requirements.

Q17. Does the Department of Human Services plan to change the MA-11 nursing facility cost report?

- A. The Department of Human Services revised the MA-11 Financial and Statistical Report and instructions effective January 1, 2019. The revised MA-11 has been modified to assure that data related to CHC program is captured in the cost reporting process. Also, additional modifications, which are not related to CHC, were made to certain MA-11 instructions for clarification purposes. Use of the revised cost report will be mandatory beginning with the periods ending December 31, 2018 and thereafter.

For additional information, see MA Bulletin 03-18-05, Electronic Submission of the Cost Report (MA-11) Form for Reporting Periods Ending 12/31/18 and Thereafter at:

<https://www.dhs.pa.gov/docs/For-Providers/Pages/Bulletin-Search.aspx>

Q18. Prior to the nursing facility rate stabilization announcement to support continuity of care, providers signed contracts with some CHC-MCOs. How will these contracts be affected by this announcement?

- A. Providers should contact the CHC-MCOs to discuss reimbursement and contracting.

Q19. Will the nursing facility per diem rate on 12/31/17 be the same rate on January 1 of each CHC phase or will it be the fourth quarterly average rate?

- A. For each CHC phase, the Department of Human Services expects the CHC-MCOs to reimburse nursing facilities at the facility level as the average of each nursing facility's per diem rates in effect for the four quarters prior to implementation; supplemental payments are not part of this calculation.

Q20. How will the quarterly Case Mix Index (CMI) effect rates in the future?

- A. The Department of Human Services (DHS) will continue to set quarterly per diem rates for each nonpublic nursing facility provider under 55 Pa. Code Chapter 1187, and 62 P.S. Chapter 443.1(7)(iv) and annual per diem rates for each county nursing facility provider under Chapter 1189. DHS will take into account fee-for-service (FFS) rate increases and assumed increases to nursing facility costs caused by subsequent mandates on staffing, wages or related cost drivers enacted following implementation when calculating CHC's capitated rates. These increases can then be negotiated between the CHC-MCOs and the nursing facilities.

Q21. Will the CHC-MCOs follow the correct Department of Human Services regulations and policy for determining Vent and DSH Share payments, i.e. occupancy percentages for DSH Share etc.

- A. The Department of Human Services and the nursing facility associations are providing technical assistance to the CHC-MCOs related to these payments. If a nursing facility is eligible for one of these payments, they should discuss the payment with the CHC-MCOs.

Q22. Are the current fiscal year nursing facility supplemental payments and County Quality and Access to Care payments for dates of service prior to January 1, 2018, being paid through fee-for-service and payments after January 1, 2018 being paid through CHC-MCOs?

- A. Yes, any current nursing facility supplemental payments for dates of service prior to January 1, 2018 will be paid through fee-for-service (FFS). Funds for dates of service on or after January 1, 2018 related to quarterly supplemental payments for nonpublic nursing facilities, assessment-related allowable cost for nonpublic nursing facilities, county MDOI and County quality and access to care payments are included in CHC agreement Appendix 4. CHC-MCOs must pay these amounts in addition to the nursing facility per diem rate. The CHC-MCOs will negotiate with the nursing facility associations how the payments will be made to the nursing facilities based on contractual responsibilities for the delivery of services.

Q23. Will there still be a 15-day hospital bed hold and 30-day therapeutic leave?

- A. CHC-MCOs are responsible for payment of medically necessary nursing facility services, including bed hold days up to fifteen (15) days per hospitalization and up to thirty (30) therapeutic leave days per year if a participant is admitted to a nursing facility or resides in a nursing facility at the time of enrollment. Nursing facility providers should contact the CHC-MCOs to discuss specific reimbursement.

Questions Added December 2, 2019

Q24. Do caregivers who work over 40 hours per week receive overtime under CHC?

- A. The federal Fair Labor Standards Act (FLSA) requires most Home Care workers to be paid the federal minimum wage for all hours worked and overtime pay at one and a half times the regular rate of pay for all hours worked over 40 in a workweek.

For more information, please reference the US Department of Labor's Fact Sheet: Application of the Fair Labor Standards Act to Domestic Service, Final Rule which can be accessed at <https://www.dol.gov/whd/regs/compliance/whdfsfinalrule.pdf>, the US Department of Labor's Home Care Guide at https://www.dol.gov/whd/homecare/homecare_guide.pdf.

Q25. Will an organization with several branch offices in PA have the same rate of reimbursement across all branches?

- A. Under CHC, the CHC-MCOs will negotiate rates with providers. Providers should contact the CHC-MCOs to discuss the rate of reimbursement across zones.

Q26. How are you addressing the DCW crisis including assisting agencies in hiring qualified, experienced, and skilled care givers?

- A. Per Section V-A-19, Service Delivery Innovation, of the CHC Agreement, the CHC-MCOs must promote innovation in the CHC service delivery system. Initial required target areas for CHC-MCO innovation include workforce innovation that improves the recruitment, retention, and skills of direct care workers. The CHC-MCOs must develop a rate configuration that assures that the extended continuity of care period condition will be met and that assures access, quality of life and quality of care. To that end, the existing fee schedule rates for personal assistance services (PAS) were increased by 2 percent effective January 1, 2020. The intent of the increase is to provide a wage increase for direct care workers providing PAS.

Quality and Oversight

Q1. Is there a Pay For Performance (P4P) or incentive program in place? If so, what will be the criteria for this program?

- A. At this time, there is no provider-based Pay for Performance (P4P) program. The Department of Human Services may consider establishing a P4P program in the future to assist participants to remain financially eligible by successfully completing the redetermination process with their local County Assistance Office (CAO) and provide incentives to improve quality and services.

Q2. What are launch indicators?

- A. Launch indicators are key data points that are used to gauge how CHC is performing in real time. The Department of Human Services (DHS) will monitor launch indicators during each phase of the CHC program implementation to assess the extent to which participants and providers experience continuity through the transition – that participants continue to receive services without interruption, and providers participate and get paid for delivering those services.

For example, launch indicators that may enable DHS to gauge whether consumers are receiving services include the number of participants who received a home and community-based service in the past week and the number of participants who received a risk screening in the past week.

Q3. Will the same measure be reported multiple times?

- A. There may be multiple indicators of the same measure. For example, in measuring whether consumers receive services, indicators may include the number of participants who received a home and community-based service in the past week and the number of participants who received a risk screening in the past week.

Q4. Will nursing facility records still be reviewed as part of the Office of Long-Term Living's (OLTL) utilization management teams review process?

- A. OLTL's utilization management teams will continue to monitor minimum data sets and pre-admission screening and resident reviews. These teams will also monitor Medical Assistance (MA) billing until CHC starts in a zone.

Q5. Will the Utilization Management Review (UMR) and Quality Management Efficiency Teams (QMET) continue to review and audit a provider's billing and claims?

- A. The functions done by the UMR and QMET teams today will be the role of the CHC-MCOs in CHC. The CHC-MCOs will be responsible for reviewing and auditing provider's billing and claims. As part of its required compliance plan, the CHC-MCOs will establish policies and procedures for review of provider claims.

The Department of Human Services through its oversight responsibility will monitor utilization and quality through reports and financial information submitted by the CHC-MCOs.

Q6. How will quality be measured in CHC and will the CHC quality plan be able to be modified to include any new or updated validated quality indicators?

- A. The measures in the CHC quality plan are fluid and may be updated to reflect the needs and outcomes of CHC. The Statewide Quality Strategy Plan currently has themes to ensure:
1. Participant and Provider Support Mechanisms
 2. Stakeholder Engagement
 3. Program Transparency
 4. Participant Choice
 5. Diversity and inclusion

The CHC-MCO agreement includes detailed standards and requirements relating to quality measures. The Department of Human Services has also engaged the Health Policy Institute's Medicaid Research Center at the University of Pittsburgh to conduct a multi-year evaluation of CHC to determine whether the program is meeting its stated goals. The University's plan is available at

<http://www.healthchoices.pa.gov/info/resources/publications/community/evaluation-plan/index.htm>

Q7. Are there any requirements in CHC to measure participant satisfaction?

- A. CHC-MCOs must implement Quality Management (QM) and Utilization Management (UM) programs that contain procedures for participant satisfaction surveys that are conducted on at least an annual basis. The survey procedures are to address the collection of annual participant satisfaction data through application of the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) instrument as outlined in Exhibit W(2) of the CHC Agreement and the Healthcare Effectiveness Data and Information Set (HEDIS®). The Department of Human Services will continue to monitor the development of evidence-based long-term services and supports satisfaction surveys and reserves the right to implement a CAHPS®, CAHPS-like, or other survey at a later date.

Q8. Will CHC-MCOs be required to use a Centers for Medicare and Medicaid Services (CMS) approved vendor for processing Consumer Assessment of Healthcare Providers and Systems (CAHPS®)?

- A. The CHC-MCO must enter into an agreement with a vendor that is certified by The National Committee for Quality Assurance (NCQA) to perform CAHPS® surveys. The CHC-MCO's vendor must perform the CAHPS® Adult and Home and Community-Based survey using the most current CAHPS® version specified by NCQA.

Q9. How will the CHC-MCOs measure the effectiveness of the coordination with the Behavioral Health MCOs (BH-MCO)?

- A. The CHC-MCO must provide for a Behavioral Health (BH) Coordinator who is a behavioral health professional and is located in Pennsylvania. The BH Coordinator shall monitor the CHC-MCO for adherence to BH requirements in this Agreement. The primary functions of the BH Coordinator are:
1. Coordinate participant care needs with BH providers.
 2. Develop processes to coordinate behavioral healthcare between primary care physicians and BH providers.
 3. Participate in the identification of best practices for BH in a primary care setting.
 4. Coordinate behavioral care with medically necessary services.
 5. Be knowledgeable of the BH Managed Care Agreement requirements and coordinate with the BH-MCO to effectuate the requirements.

Q10. When a participant requests or receives fewer units than what was approved, will the home care office providing these services be penalized for not providing 100% of the approved services?

- A. The Department of Human Services will be monitoring when a participant does not receive services as identified on the Person-Centered Service Plan (PCSP). The Department will follow up with the CHC-MCO when trends are identified. Providers should discuss with the CHC-MCOs how they will handle situations where a home care provider does not render 100% of the approved services.

Q11. Ideas for CHC innovation, where do those go?

- A. Email innovation ideas, questions and comments about the CHC program to RA-PWCHC@pa.gov

Q12. Who will be the surveyor for home health agencies after 1/1/18 instead of the Quality Management Efficiency Teams (QMET) and the Pennsylvania Department of Health?

- A. The Pennsylvania Department of Health (DOH) will continue to survey home health agencies after the CHC implementation. Once CHC begins in a zone, Home and Community-Based Services (HCBS) providers rendering services only through CHC will no longer receive Quality Management Efficiency Teams (QMET) visits. CHC-MCOs will be responsible for the quality monitoring of their providers. The Department of Human Services will monitor quality as part of their oversight function.

Q13. Will CHC-MCOs be responsible for the nursing facility care plans, and what happens to the care plan during the Pennsylvania Department of Health (DOH) review?

- A. Nursing facilities are responsible to develop care plans and provide services consistent with state licensing requirements and federal conditions of participation. The Department of Health will continue to enforce state licensing requirements and act as the State Survey Agency for federal survey and certification purposes.

The CHC-MCO will review a participant's nursing facility care plan and use this information in developing the Person-Centered Service Plan (PCSP). The CHC-MCOs will determine the roles of the nursing facility in the PCSP process. Nursing facilities should discuss roles in PCSP development with the CHC-MCOs.

Q14. Will the CHC-MCO and Independent Enrollment Broker (IEB) meet Department of Health (DOH) requirements related to background checks prior to having access to nursing facility residents?

- A. The CHC-MCO and IEB must, at their own expense, arrange for a criminal background check for each of its employees, as well as the employees of any of its subcontractors, who will have access to Commonwealth data and information technology facilities, either through on-site access or through remote access. Background checks must be conducted via the Request for Criminal Record Check form and procedure found at <https://epatch.state.pa.us>. If an employee has not been a resident of Pennsylvania for the last two years, an FBI clearance check from the state of residence during the last two years, is required. The background check must be conducted prior to initial access, prior to the provision of intake and enrollment services by the individual, and thereafter on an annual basis.

The CHC-MCO and IEB must arrange, at their own expense, for a child abuse clearance for all personnel who will have contact with children (e.g., home visit with a potential program consumer who has children) at the time of hiring.

Q15. Will providers have incentives or penalties for potentially preventable admissions to hospitals?

- A. The Department of Human Services has established a policy goal to increase efficiency and effectiveness. The program will increase the efficiency of health care and long-term services and supports by reducing potentially preventable admissions to hospitals, emergency departments, nursing facilities and other high-cost services, and by increasing the use of health promotion, primary care and home and community-based services (HCBS).

DHS expects the CHC-MCOs to move toward value-based purchasing arrangements that support the goal of reducing preventable admissions. CHC-MCOs may consider incentives such as potentially preventable admissions in future provider contracting arrangements.

Q16. Will the CHC-MCOs audit providers?

- A. The CHC-MCO must develop and implement administrative and management arrangements and procedures and a mandatory written compliance plan to prevent, detect, and correct fraud, waste, and abuse that contains the elements described in the Centers for Medicare and Medicaid Services (CMS) publication “Guidelines for Constructing a Compliance Program for Medicaid Managed Care Organizations and Prepaid Health Plans” found at:

<https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/Downloads/mccomplan.pdf>

Q17. Will the Department of Human Services’ Office of Long-Term Living (OLTL) audit the CHC-MCOs?

- A. OLTL will be responsible for overall administration and oversight of CHC. Some examples of OLTL oversight include setting provider standards, conducting readiness reviews, monitoring the CHC- MCOs, paying the CHC-MCOs and setting/monitoring capacity. OLTL will conduct ongoing monitoring to ensure that the CHC-MCOs maintain provider networks that enable participants a choice of providers for needed services. Please refer to Exhibit O of the CHC Agreement for more information.

Q18. How will the CHC-MCOs monitor a provider's performance?

- A. Providers should contact the CHC-MCOs to discuss performance metrics and evaluation criteria used to monitor the provider's performance.

Service Coordination

Q1. When will participants select their service coordinators for CHC implementation and then after the 180-day continuity-of-care period?

- A. Participants who transition into CHC at the implementation date for the CHC zone will have a 180-day continuity-of-care period for their long-term services and supports (LTSS), including service coordination. This means that the CHC-MCOs are required to continue services through all existing providers, including service coordination entities, for 180 days.

Before expiration of the 180-day continuity-of-care-period, CHC-MCOs will notify participants how their service coordination will be provided and whether their existing service coordination entity (SCE) will continue to provide services as the CHC-MCO's subcontractor. If the CHC-MCO does not contract with the participants existing SCE, the CHC-MCO will give participants the opportunity to choose a new service coordinator from amongst those employed by or under contract with the CHC-MCO.

Q2. How and when will providers know which CHC-MCO is contracting with which service coordination entity? And when will providers receive this information?

- A. The CHC-MCOs will be responsible for service coordination under CHC. Providers should discuss service coordination with the MCOs.

Q3. What happens to Service Coordination Entities (SCEs) after the Continuity-of-Care period?

- A. All existing SCEs on the date of implementation for each CHC zone are covered by the continuity-of-care period. After the continuity-of-care period ends, the CHC-MCO can decide to continue contracting with the SCE, conduct service coordination themselves, or execute a mixture of contracting and direct service coordination. CHC-MCOs are responsible for service coordination under the CHC agreement and are given the flexibility to decide how it is administered.

Q4. Will CHC-MCOs have their own internal Service Coordination Entities (SCE) or will that be subcontracted to the existing SCEs?

- A. CHC-MCOs are responsible for service coordination under the CHC agreement and are given the flexibility to decide how to administer it. All existing SCEs that are enrolled in the PA Medical Assistance Program on the date of implementation for each CHC zone are covered by the continuity-of-care period. After the continuity-of-care period, the CHC-MCO can decide to continue contracting with SCEs, conduct service coordination themselves, or do a mixture of contracting and direct service coordination. If a CHC-MCO chooses to discontinue with a SCE at the end of the continuity-of-care period, the CHC-MCO must comply with the provider termination requirements in Exhibit V, which includes notifying the Department of Human Services (DHS) and the participants and providing the DHS with a termination work plan. If a SCE chooses to end contracting with a CHC-MCO at the end of the continuity-of-care period, the CHC-MCO must also comply with the provider notification requirement in Exhibit V.

Q5. How many service coordination entities will be contracted by the CHC-MCOs?

- A. During the continuity-of-care period, the CHC-MCOs must contract with all willing and qualified entities. After the continuity-of-care period, the CHC-MCOs will determine subcontracting arrangements. The CHC-MCOs should be contacted to discuss this topic.

Q6. Will the CHC-MCOs have a local office in each region?

- A. The CHC-MCO must have an administrative office within each CHC zone. In its discretion, the Department of Human Services (DHS) may grant exceptions if the CHC-MCO has administrative offices located elsewhere in Pennsylvania and the CHC-MCO is in compliance with all standards set forth by the Pennsylvania Department of Health (DOH) and Pennsylvania Insurance Department (PID).

Q7. Will referrals be made from the service coordinators or from the CHC-MCOs and what is the process?

- A. The CHC-MCOs will develop and issue the Person-Centered Service Plan, which includes referrals. Providers should contact the CHC-MCOs to discuss any questions.

Q8. If a service coordination entity contracts with all CHC-MCOs, should participants expect to continue working with the same service coordinator as they have now?

- A. CHC-MCOs are responsible for service coordination under the CHC Agreement and are given the flexibility to decide how to administer it. Every participant receiving long-term services and supports will choose a service coordinator. While participants who are transitioning into CHC at the implementation date for the CHC zone will have a continuity-of-care period for their service coordinator, participants who transition between CHC-MCOs after the implementation date will not have a continuity-of-care period for their service coordinators. If requested after the continuity-of-care period, participants may continue working with the same service coordinator if the service coordination entity is contracted with the CHC-MCO.

Q9. Can service coordinators and supervisors only work with participants from one of the CHC-MCOs?

- A. No, if a Service Coordination Entity subcontracts with multiple CHC-MCOs, they could potentially serve participants from all MCOs. Service Coordination Entities interested in providing ongoing service coordination under CHC should contact the CHC-MCOs to discuss potential subcontractor agreements. Service coordinators will continue providing services through the Office of Long-Term Living (OLTL) OBRA Waiver and ACT 150 Program.

Q10. Can service coordinators and supervisors subcontract with more than one CHC-MCO or is it exclusive?

- A. Yes, a Service Coordination Entity may subcontract with one or more CHC-MCOs. During the continuity-of-care period, the CHC-MCOs must contract with all willing and qualified entities. After the continuity-of-care period, the CHC-MCOs will determine subcontracting arrangements. The CHC-MCOs should be contacted to discuss this topic.

Q11. Are Service Coordination Entities (SCE) required to be conflict free under CHC?

- A. Yes, the conflict-free requirements apply whether the CHC-MCOs own employees act as service coordinators or the CHC-MCO contracts with an SCE. SCEs, either CHC-MCO employees or subcontracted arrangements, cannot be a related party to a Medicaid provider.

Q12. From a participant's perspective, how will a conflict of interest impact them?

- A. The conflict of interest restriction helps to ensure that the participant has the freedom to choose the long-term services and supports provider of their choice without undue pressure or incentives to steer individuals toward or away from certain choices.

Q13. If service coordination is provided by non-CHC-MCO staff and contracted out, does the service coordination entity need to be an "enrolled Medicaid provider" in order for the CHC-MCO to contract with them for this service?

- A. Service Coordination Entities (SCEs) do not need to be enrolled as a Medical Assistance provider after the continuity-of-care period to subcontract with a CHC-MCO to provide SCE. However, SCEs will be required to maintain their enrollment status as a Medical Assistance provider with the Office of Long-Term Living (OLTL) in order to provide, and be reimbursed for, services under the OLTL OBRA Waiver and Act 150 Program.

Q14. If the service coordination entity is a Medicaid provider only, do they need to become a Medicare provider as well in order to participate in CHC?

- A. Current Service Coordination Entities (SCE) should check with the CHC-MCOs on their credentialing requirements. CHC-MCOs are responsible for service coordination under the CHC Agreement and are given the flexibility to decide how to administer it. All existing SCEs that are enrolled in the Pennsylvania Medical Assistance Program on the date of implementation for each CHC zone are covered by the continuity-of-care period. After the continuity-of-care period, the CHC-MCO can decide to continue contracting with SCEs, conduct service coordination themselves, or do a mixture of contracting and direct service coordination.

Q15. Will there be a process by which a service coordinator who has multiple years of direct experience providing service coordination be grandfathered if they don't have a social work or a related degree?

- A. Service coordinators hired prior to the CHC zone implementation date must have the qualifications and standards proposed by the CHC-MCOs and be approved by the Department of Human Services (DHS). Service coordinator supervisors hired prior to the CHC zone implementation date (who are not an RN or have a Master's degree in social work or in a human services or healthcare field and three years of relevant experience and be a Pennsylvania-licensed social worker or Pennsylvania-licensed mental health professional) must either: 1) obtain a license within one year of the implementation date of CHC in the applicable CHC zone; or 2) have the qualifications and standards proposed by the CHC-MCOs and approved by the DHS. Current service coordination entities should check with the CHC-MCOs on this question.

Q16. Are the three CHC-MCOs working together regarding service coordination and supervisor educational requirements for consistency across the CHC-MCOs? If yes, what are they and what is the process for consideration?

- A. The CHC-MCOs should be contacted to discuss this topic.

Q17. Will each CHC-MCO provide specific training for service coordinators and supervisors to learn compliance?

- A. The CHC-MCOs are required to train providers on service coordination. The CHC Agreement requires that each CHC-MCO must submit and obtain prior approval from the Department of Human Services of an annual provider education and training work plan that outlines its plans to educate and train network providers. This includes educating contracted and non-contracted providers regarding needs screening, comprehensive needs assessment and reassessment, service planning system and protocols, and a description of the provider's role in service planning and service coordination. Current service coordination entities should contact the CHC-MCOs to learn more about their training plans.

Q18. Will Service Coordinators be available 24-hours a day?

- A. The CHC-MCO's participant services functions must be operational at a minimum during regular business hours (9:00 a.m. to 5:00 p.m., Monday through Friday), plus one evening per week (5:00 p.m. to 8:00 p.m.) or one weekend per month to address non-emergency problems encountered by participants. The CHC-MCO must have arrangements to receive, identify, and resolve in a timely manner emergency participant issues on a 24 hour-per-day, seven day-per-week basis. The CHC-MCO must forward all telephone calls received by the participant service area in which the caller requests his or her service coordinator to the participant's service coordinator.

In the event a call is received beyond the hours of availability, CHC-MCO staff must record a message, including the participant's name, participant identification number and call back number, and forward the information to the service coordinator staff for a return call. The service coordinator or the service coordinator's designated back-up person must return the call as soon as possible but no longer than two business days from the receipt of the call unless the participant indicates the need for immediate assistance. The CHC-MCO will then direct the participant to the Nurse Hotline for assistance.

Q19. For participants who have Medicare with a different health plan than the CHC MCO, how will these plans share medical information so that service coordinators are informed about hospitalizations in a timely manner?

- A. The CHC-MCO must specify how it will coordinate with the participant's Medicare coverage in the participant's Person-Centered Service Plan.

Q20. What will be the service coordination case load?

- A. The CHC-MCOs are required to have sufficient staff to service participants. The CHC-MCO must annually submit and obtain the Department of Human Services approval of its service coordination staffing plan, including a staff-to-participant ratio. Providers should contact the CHC-MCOs to learn their specific staffing ratios.

Q21. What is the anticipated caseload for service coordinators, and will this conflict with behavioral health case management services?

- A. The CHC-MCOs are required to have sufficient staff to service participants. Providers should contact the CHC-MCOs to learn their specific staffing ratios. To enhance the treatment of participants who need both CHC and behavioral health services, the CHC-MCO must develop and implement written agreements with each BH-MCO in the CHC zone regarding the interaction and coordination of services provided to participants.

Q22. How will the service coordinator role be different whether internal at the CHC-MCO or external at a contracted provider? Will the CHC-MCOs share the scope for contracted services?

- A. The CHC-MCOs will determine the roles of employed service coordination staff versus subcontract service coordination staff. The CHC-MCOs should be contacted to discuss the roles.

Q23. What will the role of the CHC-MCO housing coordinator be in relation to the service coordinator?

- A. The service coordinator oversees the Person-Centered Service Plan (PSCP). Housing is one component of the PSCP, and the housing coordinator is part of the PCSP team. The CHC-MCO should be contacted to learn more details on the roles.

Q24. Will nursing home transition and service coordination be merging under CHC?

- A. During the continuity-of-care period, the CHC-MCOs must contract with all willing and qualified nursing home transition and service coordination entities. After the continuity-of-care period, the CHC-MCOs will determine the roles and subcontracting arrangements for nursing home transition. The CHC-MCOs should be contacted to discuss this topic.

Q25. How important is transitions of care in CHC and to the CHC-MCOs?

- A. Transitions of care are vitally important to the CHC program. Many of the CHC goals are dependent on improved transitions of care to serve more individuals in the community, strengthening coordination, enhance quality, and increase efficiency and effectiveness.

Questions Added on December 2, 2019

Q26. Does each participant get assigned a specific service coordinator with the CHC-MCO?

- A. Per Section V-J of the CHC Agreement, CHC-MCOs must provide each Participant with a choice of at least two Service Coordinators.

Q27. What is the CHC-MCO's/SC's role while a consumer is in the hospital? Are they calling for updates and discharge information?

- A. The fundamental requirements of a service coordinator are the same as they were in the fee-for-service waivers. One of the objectives of CHC is to improve the coordination of care for participants. Under CHC, the service coordinator will coordinate Medicare, long-term services and supports, physical health services and behavioral health services. This includes actively engaging with hospital social workers and other health care providers to ensure seamless coordination between physical, behavioral and support services.

General CHC Participant Related

Prescriptions

Q1. Will CHC participants need to show their CHC-MCO plan Identification (ID) card at the pharmacy?

- A. Yes, participants should show all health care coverage cards at the pharmacy. Pharmacies are required to verify a participant's CHC eligibility and to check if the participant has Medicare or other private insurance coverage before filling a prescription. When a participant goes to a pharmacy, the participant should be prepared to show proof of coverage, i.e. Medicare coverage (i.e., Original, MAPD, or D-SNP), the Access card (to verify MA eligibility) and the CHC-MCO plan card.

Q2. The prescription costs on the CHC Health Plan Comparison Chart are different from the Low-Income Subsidy(LIS)/Extra Help costs. Is the pharmacy going to bill Medicare Part D first and the CHC-MCO plan second?

- A. The pharmacy will bill the appropriate Medicare plan first. If the prescription is not covered by Medicare but is covered by the Medical Assistance (MA) Program, the prescription will be covered by CHC and MA co-pay will apply. Whether or not LIS or CHC covers Medicare copays or additional costs depends on the individual and his or her eligibility. To help participants effectively use their Medicare and MA drug coverage, the CHC-MCO must offer assistance to dual eligible participants in selecting a Medicare Part D plan, including advising on the benefit of enrolling in a Medicare Part D plan with a zero co-pay.

Q3. Prescriptions for those residing in a Long-Term Care (LTC) Facility were at \$0. Is this changing with CHC?

- A. No. All outpatient drugs are copay exempt for MA beneficiaries in LTC or intermediate care facilities.

Services

Q4. Revised March 20, 2018 – Question and response moved to Medicare section

Q5. When would a participant who is not receiving long-term service and supports (LTSS) use their CHC-MCO plan ID card? Do they show it to the provider for any services even if they are enrolled in a dual eligible special needs plan (D-SNP)?

- A. When a participant goes to a provider, the participant should show identification cards for all his or her healthcare coverage. If the participant is eligible for Medicare and Medical Assistance coverage, the participant should show his or her Medicare card (i.e., Original, MAPD, or D-SNP), the Access card (to verify MA eligibility) and the CHC-MCO plan card.

If a participant is enrolled in his or her CHC-MCO's companion D-SNP, the CHC-MCO will issue a single ID to the participant for both the CHC-MCO and the D-SNP.

Q6. Revised March 20, 2018 – Question and response moved to Medicare section

Q7. The CHC enrollment form mentions a community spouse. What does this mean?

- A. The community spouse is a person living in the community who is the spouse of an individual residing in a nursing facility (NF) or receiving home and community-based services (HCBS).

Q8. On the enrollment brochure in the “CHC does not change your Medicare” box, it states that “You can choose to have your CHC health plan also be your Medicare plan. Your CHC health plan will send you details about their Medicare plan.” How many ID cards would a participant receive under this scenario?

- A. If a CHC participant chooses to enroll in the companion D-SNP of his or her CHC-MCO, the CHC-MCO will issue a single ID card to the participant which can be used for both the D-SNP and the CHC-MCO.

Q9. What is a participant’s recourse if the CHC-MCO reduces his or her services?

- A. If a CHC-MCO reduces a participant’s services, the participant may file a complaint or grievance with the CHC-MCO. If the participant needs help filing a complaint or grievance, a staff member of the CHC-MCO will help the participant. The staff person can also represent the participant during the complaint or grievance process. The participant does not have to pay for the help of a staff member. This staff member will not have been involved in any decision about the participant’s complaint or grievance.

The participant may also have a family member, friend, lawyer or other person help them file their complaint or grievance. This person can also help the participant if they decide they want to appear at the complaint or grievance review. For legal assistance the participant can contact their local legal aid office at 1-800-322-7572, visit (www.palegalaid.net) or call the Pennsylvania Health Law Project at 1-800-274-3258 (www.phlp.org).

All CHC services must be medically necessary and LTSS must be identified in the standardized needs assessment and specified in the participant’s Person-Centered Service Plan.

Assessment Process

Q10. Will I be re-assessed with the new tool when I transition to CHC?

- A. CHC participants with an existing service plan must receive a comprehensive needs assessment (CNA) within 180 days of their CHC start date. The CNA will be performed using the interRAI™ Home Care (HC) assessment. Once the CNA is complete, the participant's person-centered planning team – including their service coordinator (SC) and participant's representatives – will engage in a person-centered planning process to complete the individual's service plan.

The CHC-MCO must continue to provide services in accordance with the participant's current service plan for at least 180 days. If the service planning process takes longer than the 180-day continuity of care period, the individual must continue to receive services in accordance with their current plan until the new service plan is completed and implemented.

Q11. What impact does the new tool have on the Person-Centered Service Plan (PCSP)?

- A. Implementation of the interRAI™ HC assessment tool is intended to provide a more consistent and reliable assessment of individual needs, to help ensure that participants' needs are being met in a way that suits their preferences and goals. The interRAI™ HC assessment tool is currently used worldwide and in many states as a way of gathering data about individual health and LTSS needs, as well as preferences, goals, and informal supports. The participant's person-centered planning team uses the information gathered through the CNA and conversations with the participant during the development of the PCSP.

Q12. Does the interRAI™ HC assessment tool use an algorithm to determine my hours?

- A. No. The interRAI™ HC assessment tool gathers information about participants' physical health, behavioral health, social, psychosocial, environmental, caregiver, LTSS, and other needs, as well as preferences, goals, housing, and informal supports. The severity and complexity of needs identified in the interRAI™ HC assessment tool will impact authorization of services in a participant's person-centered service plan (PCSP), but the interRAI™ HC assessment tool does not assign specific hour allotments using an algorithm.

Q13. Was the interRAI™ HC assessment tool tested on participants?

- A. Yes. The interRAI™ HC assessment tool is used for HCBS programs service planning in many states.

Q14. How are assessors being trained on the interRAI™ HC assessment tool?

- A. CHC-MCOs will ensure that SCs are trained on the interRAI™ HC assessment tool.

Person-Centered Service Plan (PCSP)

Q15. Will the PCSP process change under CHC?

- A. **Revised May 1, 2018** – The PCSP process will be similar to how it is today. CHC-MCOs will be required to develop and implement PCSPs that address how the participant’s physical, cognitive and behavioral health needs will be managed, including how Medicare coverage (if the participant is dual eligible) will be coordinated and how the participant’s LTSS will be coordinated.

PCSPs must be developed by the service coordinator, the participant, the participant’s representative, and the person-centered planning team. The team may include participants, their caregivers, primary care physicians, specialists, behavioral health providers and any other individual involved in the participant’s service planning. PCSPs must be completed no more than 30 days from the date that the CNA or reassessment is completed. Services must be specified in the participant’s PCSP and determined necessary in accordance with the participant’s assessment. Participants may appeal part or all of their service plan as provided through the CHC-MCO’s complaint and grievance procedure and the Department of Human Services fair-hearing process. *Please refer to Q1 in the Complaints and Grievances section of this document for more information.*

Q16. What if a participant does not like his or her SC?

- A. CHC does not change a participant’s ability to request a new SC.

Managed Care Organization (MCO)

Q17. How often can participants change plans? Can they switch mid-month?

- A. A participant has the right to change his or her CHC-MCO at any time; however, when the participant’s enrollment in the new plan will take effect depends on when the participant requests the transfer based upon the dating rules. Generally, if a participant requests to transfer to a new plan during the first half of the month, the participant’s enrollment in the new plan will be effective on the first day of the following month. If the participant requests to transfer during the second half of the month, the participant’s enrollment in the new plan will be effective on the first day of the second month following the transfer request. For example, if a participant makes a request to transfer to a new plan on March 2, 2018, the participant will be enrolled in the new plan effective April 1, 2018. If the participant makes the request on March 16, 2018, the participant will be enrolled in the new plan effective May 1, 2018.

The CHC-MCO is prohibited from restricting participants from changing CHC-MCOs. SCs and the independent enrollment broker will assist participants in facilitating a seamless transition between CHC-MCOs.

Q18. How can a participant get help if they want to file a complaint or grievance about their CHC-MCO?

- A. If a participant needs help filing a complaint or grievance, a staff member of the CHC-MCO will help the participant. The staff person can also represent the participant during the complaint or grievance process. The participant does not have to pay for the help of a staff member. This staff member will not have been involved in any decision about the participant's complaint or grievance.

Please refer to Q9 above for additional assistance that is available to a participant who needs help filing a complaint or grievance about their CHC-MCO.

Southwest Participant Education Meetings – Attendee Questions

- 1. Question:** Do you have to pick your doctor and your caregiver?
Response: CHC offers its participants the opportunity to make choices of who provides their care. This includes choice of participating primary care physicians (PCP), participating providers and caregivers. If your current PCP and/or provider is in the network of your CHC-MCO, you will be able to choose him or her to continue your care. If you need a new doctor or provider, tools are available at www.enrollchc.com to help you decide who that will be.
- 2. Question:** How will the financial management services (FMS) vendor work with the CHC-MCOs and how will self-directed workers be paid?
Revised Response May 1, 2018: This process will not change for participants or self-directed workers. CHC-MCOs are required to establish agreements and cooperate with the commonwealth procured Fiscal/Employer Agent (F/EA) entity in order that the necessary FMS are provided on behalf of participants. *Please refer to Q47 and Q48 in the General CHC Related section of this document for additional information.*
- 3. Question:** How does the Pharmaceutical Assistance for the Elderly (PACE) program work with CHC?
Response: The PACE program, which is the lottery-funded pharmaceutical program for seniors will not change with CHC.
- 4. Question:** What is Act 150?
Response: The state-funded Act 150 Program provides personal assistance services for people who meet nursing facility level of care, but who cannot enroll in CHC because their income levels exceed the Medicaid long-term care (LTC) financial eligibility threshold.
- 5. Question:** What is the OBRA waiver?
Response: The Omnibus Budget Reconciliation Act (OBRA) Waiver is a Medicaid-funded home and community-based waiver program for individuals who have a developmental physical disability that results in at least three substantial functional limitations, established prior to age 22, whose disability is expected to continue indefinitely and who require an Intermediate Care Facility/Other Related Condition (ICF/ORC) level of care. OBRA Waiver participants ages 21 and older who are nursing facility clinically eligible (NFCE) will transition to CHC. OBRA participants under age 21 or not NFCE will remain in OBRA.
- 6. Question:** What is an independent enrollment broker (IEB)?
Response: The IEB is an independent and conflict-free entity that is responsible for providing information about CHC and the CHC-MCOs, assisting with enrollment into CHC for long-term services and supports (LTSS), and assisting individuals to choose a CHC-MCO and enroll in a CHC-MCO.

The IEB was also responsible for providing enrollment services related to the OBRA Waiver, the Act 150 Program and the Aging, Attendant Care, and Independence waivers until those waivers were transitioned into CHC.

7. **Question:** If I am enrolled in an aligned Medicare plan, i.e. Keystone VIP Choice, Allwell Dual Medicare or UPMC For Life Dual, do I need to do anything?

Response: Yes, participants are still encouraged to select a health plan through CHC.

8. **Question:** For veterans, what happens if you have Medicare and Medicaid?

Response: Residents of state operated facilities, such as veteran's homes or state LTC units located at state psychiatric hospitals, will not be enrolled in CHC.

All other veterans who are eligible to enroll in CHC will be enrolled. The CHC-MCO will work with the veteran's other health plans to provide coordinated care.

9. **Question:** What is a managed care organization (MCO)?

Response: These are the health insurance plans that will be responsible for the physical health (PH) care and LTSS of their enrolled participants. The Department of Human Services (DHS) pays the MCO a monthly premium and the MCO provides healthcare coordination and coverage.

10. **Question:** If an adult is in a nursing facility (NF), can they remain there after choosing an MCO?

Revised Response May 1, 2018: If a CHC participant is a resident of a NF on the date CHC is implemented in the CHC zone, the participant will be permitted to continue receiving care at that NF until the participant either leaves the facility or is disenrolled from CHC, or the facility is no longer a Medicaid enrolled NF provider. *Please refer to Q8, Q10, and Q20 in the CHC Transition section, Q5 and Q19 in the Continuity of Care section and Q40 in the General CHC Related section of this document for more information.*

11. **Question:** In the future can other adults in my family, if eligible, go to the same NF?

Response: If the other adults in the family qualify for CHC and choose to use the same facility, and the facility is in their CHC-MCOs provider network and the facility accepts the family members, yes, they can go to the same facility.

12. **Question:** If I pick a CHC-MCO, can I change it later?

Revised Response May 1, 2018: Yes, participants may switch CHC-MCOs every 30 to 45 days depending on what part of the month they request the change. *Please refer to Q17 in the General CHC Participant Related section of this document for more information.*

13. **Question:** Will the CHC-MCO tell us who we have to go to? Can we go to our own primary care physician and hospital?

Response: Each CHC-MCO will have its own provider network and its participants will have an opportunity to choose providers from that network. In choosing a CHC-MCO, participants should consider which CHC-MCO has their primary care physician and other priority providers in their network.

Listings of providers in each of the three CHC-MCO networks can be found at www.enrollchc.com.

14. Question: They say everything will be coordinated. Will it really be?

Revised Response May 1, 2018: One of the objectives of CHC is to improve the coordination of care for participants. Under CHC, the service coordinator (SC) will coordinate LTSS, PH services and work with the behavioral health (BH) MCOs and Medicare. The SC will also assist in accessing, locating and coordinating needed covered services and non-covered services such as social, housing, educational and other services and supports. *Please refer to Q39 in the General CHC Related section of this document for more information.*

15. Question: How do I get information about doctors and hospitals in each of the three CHC-MCO plans?

Response: This information can be obtained by contacting the plans directly or by going to www.enrollchc.com. The three CHC-MCOs are:

- AmeriHealth Caritas Pennsylvania www.amerihealthcaritaschc.com
AmeriHealth Caritas is also known as Keystone First in the Southeast zone
<http://www.keystonefirstchc.com/index.aspx>
- PA Health & Wellness <https://www.pahealthwellness.com/members/ltss.html>
- UPMC Community HealthChoices www.upmchealthplan.com/chc

16. Question: Will I be contacted by the enrollment broker?

Response: When someone moves into CHC, they will receive a notice from DHS and a pre-enrollment packet from the IEB.

17. Question: Do I still pay the premium for Medical Assistance for Workers with Disabilities (MAWD)?

Response: CHC will not change the eligibility or premium for MAWD. Participants will continue to pay a monthly premium for coverage under MAWD.

18. Question: **Revised March 20, 2018 – Question and response moved to Medicare section**

19. Question: How often will we need to change providers? Can a CHC-MCO do that after you've been assigned one from them?

Response: Unless a CHC-MCO removes a provider from their network, participants should not need to change providers unless a provider leaves the network, or a participant chooses to change providers.

20. Question: **Revised March 20, 2018 – Question and response moved to Medicare section**

21. Question: Can I keep my mental health provider?

Revised Response May 1, 2018: If you are currently receiving your BH services through the state's Behavioral HealthChoices Program, your services will not be impacted by CHC.

If you are not currently receiving your BH services through the state's Behavioral HealthChoices Program, you should check with your mental health provider to ensure they participate in Behavioral HealthChoices. If your provider does not participate, you will have the option to continue with your current provider for the 60-day continuity of care (COC) period. At the end of that period, you will need to choose a participating mental health provider. *Please refer to the Behavioral Health section of this document for more information.*

- 22. Question:** My daughter is over 21 and on Medicare and Medicaid. She receives services through the Office of Developmental Programs (ODP). Is she eligible for CHC?
Response: In general, people with intellectual/developmental disabilities (ID/DD) who receive services through ODP are not eligible for the CHC Program. If she is NFCE and CHC would better meet her needs, she may choose to transition from the ODP waiver and into CHC.
- 23. Question:** Will I be able to go to a provider in another state for my non-emergent physical care?
Response: While there may be some limited exceptions, participants must receive services from their CHC-MCO provider's network. Participants should contact their CHC-MCO with questions.
- 24. Question:** **Revised March 20, 2018 – Question and response moved to Medicare section**
- 25. Question:** How do I know if my prescriptions will be covered under the MCO plan?
Revised Response May 1, 2018: For individuals on both Medicare and Medicaid, the CHC-MCO must provide coverage of prescription and over-the-counter medicines that are not otherwise covered by a Medicare Part D prescription drug plan. The CHC-MCO must also provide pharmacy services for all other participants. However, there are limitations if medications are written by out-of-network providers. In terms of whether or not specific prescriptions will be filled, the CHC-MCO will evaluate medications as part of the service coordination and care management process. A participant's PCP would be involved in that evaluation process. Participants should contact their CHC-MCO with questions. *Please refer to the General CHC Participant Related section of this document for more information.*
- 26. Question:** What if the service I need (chiropractor) is not covered?
Response: Chiropractor services are covered PH services under CHC. CHC participants must exhaust their available Medicare or other insurance coverage before CHC will cover a service or item.
- 27. Question:** Why is LTSS covered for 180-days of transition and the PH for only 60 days?
Response: The 60-day COC period for PH was modeled after the HealthChoices Program. Because CHC is a new program, and in order to provide additional time for providers and participants to transition to CHC LTSS, the COC period was set at 180 days.
- 28. Question:** Will I get a new Access card?
Response: No, however, participants will receive a CHC-MCO plan card. Participants should show all medical cards when they visit their providers.
- 29. Question:** Does this mean I no longer get to choose my SC?
Revised Response May 1, 2018: No. Participants will be able to choose between at least two SCs who are part of their chosen CHC-MCO. *Please refer to Q1 and Q8 in the Service Coordination section of this document for more information.*
- 30. Question:** Will I be able to use providers outside of my zone?
Response: Providers outside of your CHC zone can contract with the CHC-MCOs to provide services to participants living in your zone. Participants should contact their CHC-MCO to determine if a provider is part of their network.

31. Question: Will all facilities/providers contract with all CHC-MCOs after the CHC continuity of care period?

Response: CHC-MCOs and providers may choose if they will contract with each other. A participant should consider both LTSS and PH providers when choosing their CHC-MCO. After the applicable COC period, participants will receive their PH and LTSS from providers in the CHC-MCO's provider network.

The CHC-MCO must ensure that its provider network is adequate to provide its participants with access to quality participant care through participating professionals, in a timely manner, and without the need to travel excessive distances.

32. Question: How is Medical Assistance for Workers with Disabilities (MAWD) affected by CHC? I don't pay for Medicare Part B. It's covered by the state.

Response: The implementation of CHC will not change how the MAWD Program works. *Please refer to the Medicare section of this document for more information.*

33. Question: My mother is a patient at a nursing home. What is best for her?

Response: If your mother is a resident of a NF on the day that CHC begins in that zone, she will be able to stay in that NF for as long as she remains CHC eligible and chooses to stay there no matter which MCO she chooses.

A participant should consider both LTSS and PH providers when choosing their CHC-MCO. After the applicable COC period, participants will receive their PH and LTSS services from providers in the CHC-MCO's provider network. Participants should contact a representative from the IEB for guidance on this question.

34. Question: Are mental health medications paid for by Medicare or Medicaid? Are they considered physical medicines for behavioral care?

Response: Participant's should contact their Medicare plan to discuss coverage of mental health medications under Medicare. CHC participants must exhaust their available Medicare or other insurance coverage before CHC will cover a service or item. The CHC-MCO will not be responsible for copayments or cost-sharing for Medicare Part D prescriptions. Please contact your CHC-MCO for more information.

35. Question: Are diabetic shoes, diabetic supplies, second opinions with specialists and urgent care facilities covered under CHC?

Response: A listing of covered services can be found at www.enrollchc.com and in the participant handbook. Participants may also contact their CHC-MCO to learn about covered services and any referral or prior authorization requirements.

36. Question: **Revised March 20, 2018 – Question and response moved to Medicare section**

37. Question: Will a complaint and grievance procedure be available for CHC participants?

Response: The complaint and grievance process is contained in Section 8 of the participant handbook.

38. Question: Revised March 20, 2018 – Question and response moved to Medicare section

39. Question: Is the Living Independence for the Elderly (LIFE) program the same thing as UPMC for Life Dual?

Revised Response: No. The LIFE program is a different managed care program than UPMC for Life Dual. LIFE is a capitated LTSS program for qualifying people age 55 or older. More information on the LIFE program can be found at <https://www.dhs.pa.gov/Services/Disabilities-Aging/Pages/LIFE.aspx>. The LIFE program will continue to be a choice for individuals residing in an area that offers the LIFE program.

40. Question: What happens if after I'm enrolled in CHC, I lose either my Medicare or Medicaid?

Response: If you lose your Medicaid, you will no longer be eligible to participate in CHC. If you remain Medicaid-eligible, but lose your Medicare, you will be able to stay in CHC only if you qualify for and need LTSS. If you lose your Medicare, are Medicaid-eligible but do not need LTSS, you would be transferred to HealthChoices.

41. Question: If I am not receiving LTSS, do I have to have the health screening if I don't want it?

Response: The purpose of the health screening is to identify unmet healthcare and/or LTSS needs. As a result, DHS has made a requirement for the CHC-MCOs to screen each new participant who is not NFCE. While DHS recommends that you do the health screening, you may opt not to participate.

42. Question: Is Ticket to Work impacted by CHC?

Response: CHC will not change the way that the Ticket to Work program operates. One of the goals of CHC is to expand employment among participants who have an employment goal.

43. Question: Is it anticipated that any waiver service will be reduced? Will 24-hour coverage still be available?

Revised Response May 1, 2018: The type, scope, amount, duration and frequency of services will continue to be based on the assessed needs of participants. If, based on the needs assessment, a participant's services are reduced, the participant can file a complaint or grievance. *Please refer to Q1 in the Complaints and Grievances section of this document for more information.*

44. Question: When will we know which homecare organizations are under contract with each CHC-MCO?

Response: Please visit www.enrollchc.com to search for specific providers and whether or not they are under contract with each CHC-MCO. After you are enrolled with one of the CHC-MCOs, please refer to your participant handbook for more information.

45. Question: Will the three CHC-MCOs use the same criteria to determine services?

Response: The CHC-MCOs will use the same process when determining services as required by the DHS. DHS uses the Functional Eligibility Determination to determine whether an LTSS applicant is eligible for LTSS.

For participants who are eligible for LTSS and enrolled in a CHC-MCO, the CHC-MCO will conduct comprehensive needs assessments and reassessments using the interRAI™ Home Care (HC) assessment, which is currently used in many states across the country. This tool will inform the person-centered service plan. Reassessments are conducted once every 12 months or when a triggering event, (such as a hospitalization or change in functional status) occurs.

46. Question: Will I have freedom of choice among CHC-MCO providers?

Response: Participants can choose their providers from the CHC-MCO's provider network.

47. Question: Can we stay with the same programs instead of going into CHC?

Response: CHC is a mandatory managed care program. Participants who wish to be enrolled in the LIFE program will continue to have that option in an area that offers the LIFE program.

48. Question: Can members of the same family (husband and wife) have different CHC-MCOs?

Response: Yes. Each person will have the opportunity to choose their CHC-MCO.

49. Question: Will SCs visit nursing homes?

Response: All CHC participants receiving LTSS, whether they are in a nursing facility or the community, will have a SC.

RETURN TO TABLE OF CONTENTS