Third Thursday Webinar

July 16, 2020

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Agenda

- Community HealthChoices (CHC) Update
- Resource and Referral Tool Update
- COVID-19 Updates
  - 1915c Waiver Appendix K Transition Plan
  - Regional Response Health Collaborative Program (RRHCP)

CHC Updates

CHC Updates

- The Continuity of Care (COC) period ended on June 30th for the Northeast, Northwest, and Lehigh/Capital zones.
- CHC is now fully implemented statewide.
- The Department of Human Services is continuing to prioritize the monitoring and oversight of program operations and participant services.

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Resource & Referral Tool

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Resource & Referral Tool

- On July 8th, the Department of Human Services announced a Request for Expressions of Interest (RFEI) for the commonwealth to establish a resource and referral tool.
- The tool will serve as a care coordination system for providers and social service organizations and will include a closed-loop referral system that will report on the outcomes of the referrals.
- It will also serve as an access point to help Pennsylvanians find and access the services they need to achieve overall well-being and improve health outcomes.
- Responses can be submitted through the eMarketplace and are due by August 6th.

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COVID-19 Updates

Appendix K Transition Plan

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1915c Waiver Appendix K Transition Plan

- The Centers for Medicare & Medicaid Services (CMS) approved temporary changes to the Community HealthChoices (CHC) waiver beginning March 6, 2020 in response to the COVID-19 pandemic.

- As we begin to ease restrictions on work and social interactions, the temporary waiver changes can also be phased out, provided participants can be safely served and providers and service coordinators are taking proper precautions.

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1915c Waiver Appendix K Transition Plan

- The following slides will highlight some of the changes that will occur as counties transition to a green status.

- Please refer to the “Transition Plan to Phase Out Temporary Changes to the Community HealthChoices 1915(c) Waiver” issued by OLTL on June 26th.

- **As the COVID-19 response evolves, this guidance is subject to change based on lessons learned or due to a resurgence or other identified need.**

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1915c Waiver Appendix K Transition Plan

- **Waiver Services and Person Centered Service Plans (PCSP)**
  - When a county enters the green phase, the CHC-MCOs may begin conducting comprehensive needs reassessments that were missed due to the public health emergency (PHE) and services can be adjusted based on the outcome of the reassessment.

1915c Waiver Appendix K Transition Plan

- **Waiver Services and Person Centered Service Plans (continued)**

  – The CHC-MCOs must follow the established comprehensive needs assessment process prior to making any service reductions on the participant's PCSP.

  – Services on the PCSP that were increased or provided in a modified manner to address COVID-19 related needs are considered temporary increases/changes.

1915c Waiver Appendix K Transition Plan

- **Person-Centered Service Planning and Service Coordination**
  - When a county enters the green phase, Service Coordinators should monitor participants and PCSPs through face-to-face contacts when possible.
  - Monitoring of participants and PCSPs may be done remotely when risk factors may be present in the participant's home.

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- **Initial Level of Care Assessments**
  - Initial level of care assessments using the FED that take place in the participant's home should be conducted face-to-face when possible.
  - Assessments may be conducted remotely when risk factors may be present in the participant's home.
  - Assessors must follow the guidance issued by the Independent Assessment Entity for resuming face-to-face assessments and maintain safe behavioral practices as defined by the CDC and the Department of Health when doing so.

1915c Waiver Appendix K Transition Plan

- **Initial Level of Care Assessments (continued)**
  - Initial level of care assessments using the FED that take place in nursing facilities should be conducted remotely using phone or video conferencing.
  - Assessors should follow guidance around visitation in nursing facilities that is issued by the CDC and the Department of Health.

1915c Waiver Appendix K Transition Plan

- **Needs Assessments and Reassessments**
  - Service Coordinators must receive education and training from the CHC-MCOs on how to evaluate individual risk factors and protect themselves from potential exposure according to the guidance issued by the CDC and the Department of Health.
  - Annual Reassessments, including the needs assessment, should be conducted face-to-face when possible.
  - Reassessments may be conducted remotely when risk factors may be present in the participant's home.

1915c Waiver Appendix K Transition Plan

- **Needs Assessments and Reassessments (continued)**
  - Annual reassessments, including the needs assessment, that were delayed beyond the 365-day requirement must be completed no later than 6 months after the county has transitioned to green or the issuance of this policy, whichever is later.
  - Comprehensive Needs Reassessments should be conducted face-to-face when possible.
  - Reassessments may be conducted remotely when risk factors may be present in the participant's home.

1915c Waiver Appendix K Transition Plan

- **Personal Protective Equipment (PPE)**
  - PPE such as gloves, gowns and masks for participant use can be obtained as Specialized Medical Equipment and Supplies if no other source is available.
  - This flexibility will continue for the duration of the Appendix K approval period regardless of the county's status.

1915c Waiver Appendix K Transition Plan

- **Respite**
  - Respite in a licensed facility may be extended beyond 29 consecutive days without prior approval of the CHC-MCO, in order to meet the participant's health and safety needs.
  - When a county transitions to green, this flexibility continues if the need for additional Respite is a result of COVID-19.
  - Prior approval of the CHC-MCO is required. This remains in effect for the duration of the Appendix K approval.

1915c Waiver Appendix K Transition Plan

- **Personal Assistance Services (Agency and Participant-Directed) and Participant-Directed Community Supports**
  - When a county enters the green phase, spouses, legal guardians, and persons with power of attorney may no longer serve as paid direct care workers.
  - Participants will be expected to resume using their existing direct care worker or a replacement worker, if necessary.

1915c Waiver Appendix K Transition Plan

- The information covered in these slides is not exhaustive and the transition plan includes additional guidance addressing:
  - Expanded Settings Where Services May Be Provided
  - Modifications of Licensure or Other Requirements for Settings Where Waiver Services are Furnished
  - Incident Management Reporting Requirements
  - Retainer Payments to Address Emergency Related Issues

Regional Response Health Collaboration Program (RRHCP)

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Regional Response Health Collaboration Program (RRHCP)

- **Background**
  - In late May, the Pennsylvania Legislature approved $175 million to establish the RRHCP in the commonwealth from federal funds received via the CARES Act.
  - In early June, the Department of Human Services announced an opportunity for health systems to participate in a Request for Applications to establish the Regional Response Health Collaboration Program.

Regional Response Health Collaboration Program (RRHCP)

- **Program Overview**
  - The RHCCP will provide operations, management, and administrative support to protect residents in long-term care facilities from COVID-19.
  - The RRHCP was based on the Educational Support and Clinical Coaching Program (ESCCP), a learning network that provided technical assistance and educational support to long-term care facilities in light of the current pandemic.
  - The Department began conducting orientation and training for the selected health systems on July 16th.

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Regional Response Health Collaboration Program (RRHCP)

- **Program Components**
  - The RRHCP will be expected to provide the following support for nursing homes, personal care homes and assisted living facilities. This will also include providing assistance to other DHS-licensed facilities, Adult Living Centers and State Veterans Homes.
    - Establish a call center with 24/7 access that providers can access clinical consultation and technical assistance
    - Provide assistance with universal testing
    - Access to expertise in infection control
    - Deploy rapid response teams in case of emergency in conjunction with DOH, DHS and PEMA

  (program supports continued on following slide)

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Regional Response Health Collaboration Program (RRHCP)

- **Program Components (continued)**
  - Assess facility's capability and capacity to prevent and to respond to a COVID-19 outbreak.
  - Provide emergency preparedness for personal protective equipment assessment and coordination
  - Establish a statewide educational support resource for providers to have access to state and national resources
  - Assist providers with staff augmentation when needed
  - Work with DHS and DOH to conduct contact tracing
  - Assist providers in developing and implementing plans for alternate care settings for residents if outbreaks of COVID-19 occur at facility
  - Provide software and technical support to facilities to support two-way communication between residents and their families.

Regional Response Health Collaboration Program (RRHCP)

- **Funding for the RRHCP is divided regionally by the long-term care facility census as follows:**
  - Southeast Region ($65.8 million):
    - Thomas Jefferson University
    - University of Pennsylvania in partnership with Temple University Hospital, Inc.
  - Northeast Region ($24 million):
    - Geisinger Clinic
    - Lehigh Valley Hospital, Inc.
  - Southcentral Region ($22.9 million):
    - The Pennsylvania State University
  - Northcentral Region ($9.8 million):
    - Geisinger Clinic
  - Southwest Region ($38.9 million):
    - UPMC Community Provider Services in partnership with Allegheny Health Network and the Jewish Healthcare Foundation
  - Northwest Region ($13.6 million):
    - LECOM Health
    - UPMC Community Provider Services in partnership with Allegheny Health Network and the Jewish Healthcare Foundation

Stakeholder Meeting Resources

- **The Department of Human Services conducts several monthly stakeholder meetings:**
  - **Medical Assistance Advisory Committee (MAAC):** https://www.dhs.pa.gov/about/DHS-Information/Pages/Stakeholders/MAAC.aspx
  - **Consumer SubMAAC:** https://www.dhs.pa.gov/about/DHS-Information/Pages/Stakeholders/Consumer-Subcommittee.aspx
  - **Long-Term Services and Supports (LTSS) SubMAAC:** https://www.dhs.pa.gov/about/DHS-Information/Pages/Stakeholders/Long-Term-Services-Subcommittee.aspx.
  - **MLTSS SubMAAC:** https://www.dhs.pa.gov/about/DHS-Information/Pages/Stakeholders/Managed-Long-Term-Subcommittee.aspx

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CHC Resource Information

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

COMMUNITY HEALTHCHOICES WEBSITE: www.healthchoices.pa.gov

EMAIL COMMENTS TO: RA-PWCHC@pa.gov

OLTL PROVIDER LINE: 1-800-932-0939

OLTL PARTICIPANT LINE: 1-800-757-5042

INDEPENDENT ENROLLMENT BROKER: 1-844-824-3655 or (TTY 1-833-254-0690) or visit www.enrollchc.com

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Questions?