

Community HealthChoices Questions and Answers Document

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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. The counseling component related to methadone treatment is covered by the BH-MCO while the drug itself is paid by the 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. Enrollment in CHC automatically triggers behavioral health managed care coverage, so CHC participants should not lose coverage in their BH-MCO. If a CHC participant would lose behavioral health managed care coverage, then the participant would be covered under the fee for service delivery system. 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.

CHC-MCOs will provide three services to LTSS participants who need the following services to improve their functioning and independence and when necessary to improve their inclusion in their community:

- 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 behavioral health managed care organizations (BH-MCOs).

If an individual in a nursing facility is determined to be in need of specialized behavioral health 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. 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. The CHC-MCOs must provide and have a process for approving exceptional DME, as defined in Exhibit A(1) of the CHC Agreement, Covered Services – Long-Term Services and Supports Service Definitions. DHS will continue to publish an annual list of exceptional DME by notice in the Pennsylvania Bulletin in July, which shall be incorporated by reference and supersede the current list of exceptional DME set forth in Exhibit A(1).

Q3. What is the process for the approval of exceptional durable medical equipment (DME) requests and who is responsible for maintaining the exceptional DME list?

- A. The CHC-MCOs must provide and have a process for approving exceptional DME, as defined in Exhibit A(1) of the CHC Agreement, Covered Services – Long-Term Services and Supports Service Definitions. The Department of Human Services will continue to publish an annual list of exceptional DME by notice in the Pennsylvania Bulletin in July, which shall be incorporated by reference and supersede the current list of exceptional DME set forth in Exhibit A(1).

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. Will the CHC-MCO honor an existing exceptional durable medical equipment (DME) grant?

- A. Any wheelchairs or augmentative communication devices approved prior to January 1, 2018, the Department of Human Services will be responsible for follow-up and payment. Any bed or mattress rentals that were approved prior to January 1, 2018 but continue in the new year will be transferred to the CHC-MCO for follow-up and payment. Any request received prior to January 1, 2018 but 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 1915(c) home and community-based 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 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.

Personal Assistance 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 the Department of Human Services' requirements and specified in the participant's Person-Centered Service Plan (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 Home and Community-Based Services (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 Person-Centered Service Plan (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 to be provided under CHC?

- A. Exhibits A and A(1) of the CHC Agreement provide a list of the services covered under CHC.

Q10. What specific home adaptations are covered under CHC?

- A. 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. Exhibit A(1) of the CHC Agreement provides more information including a list of covered adaptations. Home adaptations must be specified in the participant's Person-Centered Service Plan (PCSP) and determined necessary in accordance with the participant's assessment.

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

- A. 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. Exhibit A(1) of the CHC Agreement includes a list of covered assistive technology items. Assistive Technology service must be specified in the participant's Person-Centered Service Plan (PCSP) and determined necessary in accordance with the participant's assessment.

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

- A. CHC-MCOs are required to provide non-medical transportation. Exhibit A(1) of the CHC Agreement provides more information on non-medical transportation under CHC.

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

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

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 a service coordination entity must enroll as a Medical Assistance 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 fee-for-service 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 Medical Assistance program will continue to remain the payer of last resort. All forms of third party medical coverage (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. Home and Community-Based Services (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:
http://www.dhs.pa.gov/cs/groups/webcontent/documents/document/c_172248.pdf. 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.

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 of the content of DCW pre-service orientation. Pre-service orientation must, at a minimum, cover the following topics: operational procedures and paper work, 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 preservice orientation program. The FMS Vendor may use a subcontractor to satisfy the pre-service orientation experience requirements.

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 long-term services and supports (LTSS) assessments and annual redeterminations. The IAE is contracting with local Area Agencies on Aging to do the initial level of care assessments. CHC-MCOs are responsible for using the InterRAI tool to perform comprehensive needs assessments and reassessments of nursing facility clinically eligible (NFCE) participants no more that twelve (12) months following the most recent prior comprehensive needs assessment. These comprehensive assessments must be conducted at least once every twelve (12) months, unless a “trigger event” occurs, which would require a more frequent assessment. Trigger events include 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 Independent Assessment Entity to use in making the annual redeterminations. The process will be the same for nursing facility residents and those residing in the community.

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 home care assessment fit?

- A. All CHC-MCOs are required to use the InterRAI-Home Care Assessment tool to perform needs assessments and reassessments of 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 tool, it was developed using data from the current assessment process, and is currently used in many states.

Q4. Will clinical eligibility be reviewed periodically?

- A. The IAE will be responsible for oversight of the quality and accuracy of level of care assessments that are performed by local AAAs. DHS will monitor the IAE.

Q5. With reassessments being completed every 12 months or based on trigger events, what are the requirements for contact (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 fourteen (14) days after the occurrence of one of the following trigger events:

- A significant healthcare event including but not be limited to a hospital admission or discharge;
- A change in functional status;
- A change in caregiver or informal support status if the change impacts one or more areas of health or functional status;
- A change in the home setting or environment if the change impacts one or more areas of health or functional status;
- A change in diagnosis that is not temporary or episodic and that impacts one or more area of health status or functioning; or
- As requested by the Participant or designee, caregiver, Provider, or the Person-Centered Planning Team (PCPT) or PCPT Participant, or the Department.

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 assessment?

A. The CHC-MCO will determine if the comprehensive 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 Functional Eligibility Determination (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, 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 tool, which will be used for needs assessments and redetermination, will be available to service coordinators when CHC is implemented in the southwest zone on January 1, 2018.

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

- A. Service Coordinators are responsible for comprehensive needs assessments and reassessments. Service coordinators must be a registered nurse (RN) or have a Bachelor's degree in social work, psychology, or another related field. Additionally, service coordinators must have at least 3 years of experience in a social service or health care related setting. For service coordinators hired prior to the CHC zone implementation date, the CHC-MCO will define the qualifications that their service coordinators must possess. The CHC-MCOs' proposed standards are subject to review and approval by DHS.

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 Independent Enrollment Broker (IEB) is responsible for facilitating enrollment in CHC. The Functional Eligibility Determination (FED), which determines whether a participant is clinically eligible for LTSS, will be conducted by the Independent Assessment Entity (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 Independent Enrollment Broker (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) be replaced with the functional eligibility determination (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 Functional Eligibility Determination (FED) to determine whether an LTSS applicant is clinically eligible for LTSS. The Independent Assessment Entity (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 comprehensive needs assessments and reassessments using a tool designated by DHS. DHS selected the InterRAI-Home Care (HC) tool for needs assessments and reassessments. Reassessments are conducted once every 12 months or when a triggering 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. 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. The assessors who participated in the testing phase of the Functional Eligibility Determination (FED) development were trained in April of 2017. The training was successful in informing and preparing the assessors to administer the new FED tool.

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/info/resources/publications/community/index.htm>

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

- A. In July 2017, DHS sent informational flyers to potential CHC participants in the CHC phase 1 southwest 14 counties. DHS sent pre-transition notices to these individuals in late September 2017.

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

- A. During CHC implementation, the COMMCARE waiver will become the CHC waiver. 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.

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

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

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

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

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

- A. The participant enrollment process will be similar to how it is today. Prior to CHC implementation, the Independent Enrollment Broker (IEB) will provide 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 will continue 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 will also be responsible to assist enrolled participants who wish to change their CHC-MCO with plan transfers.

The independent assessment entity will conduct the initial level of care determinations using the functional eligibility determination (FED) tool. The FED generates a nursing facility clinically eligible (NFCE) or nursing facility ineligible (NFI) designation.

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

- A. All COMMCARE participants will be transitioned to the Independence Waiver by 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, who are eligible to receive, or are receiving services through a program administered by the Department of Human Services' Office of Developmental Programs, will not be enrolled in CHC unless they are nursing facility clinically eligible and choose to enroll in CHC.

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

Community HealthChoices Transition Questions and Answers

Issued: October 18, 2017

Revised: March 20, 2018

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 by November 13, 2017, the participant will be assigned to a CHC-MCO by the automatic assignment process described in the Department of Human Services' 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 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 nursing facility ineligible (NFI) Duals will be auto-assigned.

Q12. How does CHC impact the Living Independence for the Elderly (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 upcoming 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/oltil-community-healthchoices.html>).

Q15. When will the provider receive a service authorization from the CHC-MCO for services that begin on January 1, 2018?

- A. CHC-MCOs will issue service authorizations in late December 2017 for services after January 1, 2018 using data regarding current service plans provided by the Department of Human Services' Office of Long-Term Living. DHS will forward any requests for service authorizations that are pending as of December 31, 2017 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, 2017 should be directed to the participant's CHC-MCO, as indicated in the Eligibility Verification System (EVS).

Q16. Will authorization be required for residents that are in a nursing facility before Jan. 1, 2018?

- A. Service authorizations will not be required prior to January 1, 2018 but nursing facilities should contact the CHC-MCO to learn what is required for services after January 1, 2018.

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

- A. The HC-MCO will pay for NF services up to 30 days. The HC-MCO will pay for Day 31 through the date the eligibility determination is made if a resident is found eligible to receive NF services. The CHC-MCO will begin to pay the day after the resident is found eligible to receive NF services.

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

- A. Aging waiver participants who are nursing facility clinically eligible 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, who are nursing facility clinically eligible.

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

- A. Medical Assistance nursing facility 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. The Department of Human Services 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. 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.

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

- A. Individuals 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 in mid to late September announcing informational meetings and dates.

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

Community HealthChoices Transition Questions and Answers

Issued: October 18, 2017

Revised: March 20, 2018

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

- A. A participant should consider both long-term services and supports and physical health 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 long-term services and supports participant who resides in a nursing facility is originally from a county that is not in the same phase of CHC implementation as the nursing facility?

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

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.

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).

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 MAB 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 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 (Department), or they will be auto-assigned to a plan by the Department. The Department 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 coordinator, 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 as CHC 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 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 home and community-based participant's continuity of care, when does the newly selected provider receive a service authorization?

- A. The newly selected provider will receive an updated Person-Centered Service Plan (PCSP) 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 nursing home residents when nursing home residents can stay as long as they want?

- A. CHC participants who reside in a nursing facility 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 nursing facility 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 nursing facility, 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 nursing facility 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 nursing facility 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 nursing facility services from a general county, special rehabilitation or hospital-based nursing facility which is licensed by the Pennsylvania Department of Health (DOH) and enrolled in the Pennsylvania Medical Assistance Program.

Eligibility Verification System

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

- 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 Primary Care Physician (PCP).

Q2. How is access to the Eligibility Verification System for verification of participants obtained?

- A. For more information related to the Eligibility Verification System, refer to Provider Quick Tip #11 at:

<http://www.dhs.pa.gov/publications/forproviders/QuickTips/>

Q3. What is the Eligibility Verification System?

- A. The PROMISe™ Eligibility Verification System 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:

<http://www.dhs.pa.gov/publications/forproviders/QuickTips/>

Q4. Will providers still be able to use the PROMISe™ Eligibility Verification System to verify participant eligibility for CHC?

- A. Yes, the current EVS methods, inquiry and response formats will not change with the CHC implementation. The current 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 the 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 Third Party Liability (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 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. 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.

Electronic Visit Verification System

Q1. Will Electronic Visit Verification (EVV) be required in CHC?

- A. The 21st Century Cures Act requires states to implement EVV for personal care services by January 1, 2019, and home health care services by January 1, 2023 (Sec. 207). EVV will be required for these CHC services.

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

- A. **Revised January 17, 2018** – 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 and home health care services provided by CHC. The Department of Human Services (DHS) is currently working on a Department wide approach to comply with the federal requirement. DHS intends to implement the EVV requirements so that the system is minimally burdensome and will take into account the input from stakeholders.

On January 4, 2018 DHS distributed a ListServ communication notifying stakeholders of the Department's intent to issue a survey in January 2018 to providers of personal care and home health services to better understand how many providers are currently using an EVV system, which systems are being utilized, and provider experience with available systems. DHS is also in the process of developing a request for information (RFI) which will be issued in the new year. DHS seeks to better understand available features, challenges and remedies, and best practices through the RFI. Both the survey and the RFI will be disseminated widely. DHS looks forward to further guidance from the Centers for Medicare and Medicaid Services (CMS) on the interpretation of personal care services to clarify the scope of the EVV requirements. DHS anticipates additional federal guidance, as required by the Cures Act, in January 2018. DHS will continue to inform stakeholders of next steps as we move forward in implementation planning. 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. Generally, the EVV system eliminates the need for handwritten signatures. The EVV system must verify and record electronically (for example, through a telephone or computer-based system) the following information: the type of service performed; the individual receiving the service; the date of the service; the location of the service; and the time the service begins and ends.

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, alternative technology will be used such as a smartphone or a small device installed in their home for their personal attendant to use to clock in and out. The participant will not have to pay for this device.

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 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 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 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 the Department of Human Services be able to handle the additional work with the independent enrollment broker 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. The Department of Human Services (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 that 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 http://www.dhs.pa.gov/cs/groups/webcontent/documents/form/c_261042.pdf.

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 the Department of Human Services 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 long-term services and supports, 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 Nursing Facility Clinically Eligible (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 and personal assistance provider to eliminate a conflict of interest? A few years ago it was determined to be a conflict of interest for a provider 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 (SC) as an administrative service and may provide SC with their staff or through a subcontract arrangement.

To avoid conflict concerns, the Department of Human Services (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. The IEB is playing a new role for nursing facility residents. Nursing facilities should contact the IEB to begin a Long-Term Care (LTC) application.

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 will commence on 1/1/18 and will have a five-year term.

The term of the Southeast Zone agreements will commence on 7/1/18 or a later date selected by DHS and will have a four-year term.

The term of the Lehigh-Capital, Northwest, and Northeast Zone agreements will commence on 1/1/19 or a later date selected by DHS 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 fully-executed CHC agreements will be available on the Pennsylvania Department of Treasury's website; however, the rate information will be redacted.

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/about/community/index.html>.

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 an MCO that is not affiliated with one of the three selected CHC-MCOs, the CHC participant will need to select another CHC-MCO.

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 Personal Assistance Services and employ their own personal assistance 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 the Office of Long-Term Living 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. The Department of Human Service's agreement with the CHC-MCOs requires that the CHC-MCOs include certain provisions in their provider agreements and that CHC-MCOs submit their provider contracts 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 Department of Human Services?

- A. The CHC Agreement establishes requirements, which the CHC-MCOs must meet. DHS has provided technical assistance on various topics such as housing, home and community- based services 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 Office of Long-Term Living'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 Department of Human Services (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 §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. The Department of Human Services (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 the Department of Human Services' Quality Strategy not include a CHC Ombudsman?

- A. The Medicaid Managed Care Rule requires the DHS to have a Beneficiary Support System in all of its managed care programs by July 1, 2018, including CHC. DHS is still considering how best to meet the requirement. More information will be shared in the future on the Beneficiary Support System.

Q33. How is the Department of Human Services 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 the 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 July 1, 2018 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, the Department of Human Services 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).

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/TDY 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 service coordinator 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 service coordinator will coordinate Medicare, long-term services and supports, physical health services and behavioral health services. The service coordinator 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 nursing facility clinically eligible (NFCE). An individual who is not NFCE is considered nursing facility ineligible (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. 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.

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 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.

Q44. Is the Department of Human Services 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. long-term services and supports PCSP, physical health care plan, behavioral health case management 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 service coordinator chosen by the resident.

Q46. What impact does the Department of Human Services expect CHC to have on nursing home transition (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 nursing home transition (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. The Department 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 Fiscal/Employer Agent (F/EA) procured by the Department. CHC-MCOs are required to establish agreements and cooperate with the Department's F/EA for the necessary financial management services 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 the Department of Human Services.

Independent Enrollment Broker

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

- A. As of September 20, 2017, the IEB procurement is active and in a black-out period.

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. The Department of Human Services (DHS) has oversight responsibility of the IEB's performance. DHS has issued a Request for Proposals (RFP) for a new procurement that will enhance oversight through increased reporting requirements imposition of specific service level agreements (performance standards) regarding call center performance, timeliness of enrollment functions, compliance with corrective action plans and related financial assessment or remedies for non-compliance. In addition, the selected vendor(s) 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. The IEB Request for Proposals (RFP) will impose additional requirements related to follow up on to promote timely enrollments. For example, the selected vendor(s) will be required to make three telephone attempts to contact individuals who were referred to the IEB or filed LTSS applications through COMPASS or with a CAO within seven calendar days of the referral date; to establish a follow up process to facilitate receiving the physician certifications in 30 days; and to follow up if the Functional Eligibility Determination (FED) is not completed by Aging Well within 15 calendar days of a referral.

Q6. What is the IEB's involvement with the new Functional Eligibility Determination (FED) tool?

- A. The IEB serves as the entry point for the enrollment process; therefore, the IEB will interact with the Independent Assessment Entity (IAE). The IEB receives notification from the Department of Human Services 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 Aging Well to complete a FED.

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

- A. No. The IEB's role will be 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?

- A. Yes, IEB representatives may come into a nursing facility. Currently, the IEB assists nursing facility 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 applying to receive nursing facility services through CHC with the LTSS eligibility process and in selecting or changing his/her CHC-MCO plan or, if eligible, to educate on the LIFE program. In providing enrollment assistance to these individuals, the IEB will coordinate and cooperate with the residents' nursing facilities. At a minimum, the IEB will work with the nursing facilities in scheduling visits with and facilitating functional and financial eligibility determinations for nursing facility residents. If an LTSS applicant designates a nursing facility as a contact, the IEB will also provide the nursing facility with information relating to the status of the individual's LTSS application.

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

- A. The IEB will communicate with both nursing facility staff and CHC-MCO staff when performing enrollment activities for nursing facility residents. The IEB may contact nursing facilities 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 nursing facility?

- A. The IEB will assist nursing facility residents and nursing facility staff in managing the 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 long-term services and supports applicants through the Medical Assistance clinical and financial eligibility process, and providing information on nursing home transition.

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

- A. Nursing facilities can originate the enrollment application process through COMPASS if they are a community partner. Nursing facilities may also contact the IEB to begin the application process. Nursing facilities may also complete a paper application and submit it to the CAO. 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 nursing facility?

- A. The IEB will be reimbursed by the Department of Human Services for services it provides.

Q13. How far will the IEB go to secure the necessary information required and will the County Assistance Office (CAO) use their regulatory authority to secure documents?

- A. The IEB will be required to assist an applicant complete a long-term services and supports application when providing initial assistance and to perform other tasks as required by the program.

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

- A. The IEB currently assists nursing facility (NF) residents and staff who are applying for home and community-based service. In CHC zones, they will also assist individuals, including NF residents and staff, to apply for NF services under CHC.

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's 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 and the Adult Protective Services Act.

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

Q2. Once CHC is implemented, what system will home and community-based services 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 the Department of Human Services' Enterprise Incident Management System.

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

- 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 the Department of Human Services' Enterprise Incident Management system.

Q4. Where will agencies report critical incidents for HCBS participants to -- the CHC-MCOs, OLTL, Aging?

- A. Critical incidents as defined by the Office of Long-Term Living must be reported through the Department of Human Services' Enterprise Incident Management (EIM) system. 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 Adult Protective Services (APS) and the Older Adult Protective Services Act (OAPSA) and to law enforcement for incidents that meet the specific requirements of the APS and OAPSA laws.

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

- A. Nursing facilities (NF) should report critical incidents, including preventable serious adverse events, to the CHC-MCOs. NFs will continue to submit reportable events to the Department of Health (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. Death due to malnutrition, dehydration or sepsis
 - V. Elopement inpatient
 - VI. Reportable diseases, referenced 28 PA Code 211.1 and Chapter 27 of Administrative Code/211.1(a)
 - VII. Misappropriation of resident property
 - VIII. 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
 - IX. 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
 - X. Resident neglect. Reference 42 CFR 483.13(c), 28 PA Code 201.3, and Act 13 of 1997 for definitions.
 - XI. Rape
 - XII. Receipt of strike notice
 - XIII. Significant disruption of service due to disaster such as fire, storm, flood, or other occurrence
 - XIV. Transfer/admission to hospital because of injury/accident
 - XV. 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 critical incident definition. 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 the Enterprise Incident Management (EIM) system, does that mean that HCSIS is not being dismantled?

- A. Critical incidents as defined by the Office of Long-Term Living must be reported through the Department of Human Services' Enterprise Incident Management System. After CHC implementation, providers will only use HCSIS for ACT 150 and OBRA waiver participants.

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-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 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 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 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 Dual Eligible Special Needs Plans (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 Dual Eligible Special Needs Plan (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 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 CHC cover the same service, the participant must exhaust the coverage available under the D-SNP plan before his or her CHC-MCO will pay.

Q5. If a dually 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 for Medicare 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 Dual Eligible Special Needs Plans (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 with the Medicaid 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 may cover personal assistance services. The service coordinator and Personal Assistance Services (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 nursing facility 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 is not covered by the participant's Medicare hospice benefit. The nursing facilities 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.

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 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 continuity of care 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 continuity-of-care period? If so, by what number?

- A. Following the 180-day continuity-of-care period, the CHC-MCO may adjust its provider network in accordance with the network access and adequacy standards outlined in the CHC Agreement. The Department of Human Services (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 continuity-of-care period to ensure consumers have access to long-term services and supports.

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. The DOH has worked with DHS and stakeholders in developing network adequacy standards for home and community-based services. 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 MCO to receive a Certificate of Operating Authority.

Q5. How will DHS determine that the CHC-MCOs have adequate provider contracts for home and community-based and nursing facility services?

- A. The Department of Health currently evaluates the nursing facility 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 home and community-based services (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 (FTEs) that are potentially needed to continue to provide HCBS services 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. The Department of Human Services 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 full time equivalents of direct care workers 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 direct care workers?

- 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 was a major part of the CHC-MCO go/no go decisions at the end of September 2017.

Q8. What plans exist to meet "community" needs in rural counties that do not have services available at this time? Will it affect the nursing facility 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. Nursing facilities 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. Nursing facilities should discuss the use of physician extenders with the CHC-MCOs.

Q10. Are the Department of Human Services and Department of Health 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.

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, vehicle modifications, and/or assistive technology must be enrolled directly as MA providers with the Office of Long-Term Living. Subcontracted providers must enroll as an MA provider before January 1, 2018 to be eligible to contract with CHC-MCOs in the southwest zone.

Q2. If an agency provides Personal Emergency Response Services (PERS) through their Home Care Operations Tax ID company and Medical Assistance (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 Medical Assistance (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 the Office of Long-Term Living 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 Medical Assistance (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, personal emergency response systems, vehicle modifications, and/or assistive technology must be enrolled directly as MA providers with the Office of Long-Term Living. Subcontracted providers must enroll as an MA provider before January 1, 2018 to be eligible to contract with CHC-MCOs in the southwest zone.

Questions Added on December 8, 2017

Q6. If a participant currently has a Personal Emergency Response System (PERS) and that provider does not have a Medical Assistance 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 Medical Assistance Program with the Office of Long-Term Living and contract with CHC-MCOs to provide services to CHC participants. PERS is subject to the continuity of care provision. 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.

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' independent assessment entity will conduct the annual redeterminations of clinical 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 manual 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, long-term care insurance policies or pharmacy be handled differently under CHC?

- A. No, CHC will not change how home maintenance deductions, long-term care 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 the Department of Human Services' 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 the date that the resident is enrolled in CHC (i.e., “the CHC Start Date”), including 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 the Department of Human Services’ client information system (CIS).

Q8. Will the 180-Day exception rule still exist for retroactive billing during the transition from Fee for Service (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, the Department of Human Services’ Estate Recovery Program recovers MA payments for home and community-based, 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 the Department of Human Services of Human Services 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 clinical eligible?

- A. If the Department of Human Services' independent assessment entity determines that an individual no longer needs the NF level of care (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 level of care?

- 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 Medical Assistance (MA) program.

CHC participants admitted to a NF after the CHC implementation date will receive the standard 60-day continuity of care protections. For additional information regarding the 60-day continuity of care provision, see MA Bulletin 99-03-13 which is available at:

<http://www.dhs.pa.gov/provider/BulletinSearch/index.htm>

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

- A. Participants may apply electronically through COMPASS or using the paper PA 600L, Application for Benefits.

Q15. If the resident is approved for Medical Assistance with a penalty period, does the HealthChoices (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 NF services, or long-term services and supports under CHC during the penalty period because the individual is not eligible for payment of LTC facility services or Home and Community Based Services during the penalty period.

Q16. What is the difference between the CHC long-term services and supports population and the CHC NFI Dual population?

- A. CHC covers two groups of Medical Assistance participants who are aged 21 and older:
- Participants who need long-term services and supports because they are NF clinically eligible (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 consumer who is interested in receiving long-term services and supports (LTSS)?

- A. If a consumer is interested in receiving LTSS, we recommend that the consumer contact the Independent Enrollment Broker to begin the LTSS eligibility determination process. Consumers can also file applications for MA benefits, including LTSS, online using the Department of Human Services' COMPASS system, which is available at: <https://www.compass.state.pa.us/Compass.Web/Public/CMPHome>. Consumers can also visit the local CAO to apply in person, or download an application from the Department of Human Services' 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 continuity of care period. Newly eligible CHC participants may begin receiving physical health and nursing facility 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 for You were selected to provide services on a statewide basis.

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 Independent Enrollment Broker 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 Independent Enrollment Broker (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 County Assistance Office.

Q23. For the PA-600L form, are paper applications no longer acceptable and must consumers use the Independent Enrollment Broker 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 Independent Enrollment Broker (IEB) determine financial eligibility prior to doing the MA-51 and having the Area Agency on Aging complete the level of care determination or can the NF initiate the level of care 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 Independent Assessment Entity (IAE).

Q25. What is the role of the independent enrollment broker 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 LIFE provider, processing requests to change CHC-MCO plans, providing enrollment materials, assist CHC participants and assisting LTSS applicants through the MA clinical 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 Independent Enrollment Broker will provide both NFI Dual and LTSS participants with information about CHC and their CHC-MCO options so that 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 process if a provider wishes to terminate providing services with a participant?

- A. The CHC-MCOs must develop provider policies, which the Department of Human Services 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 Department of Human Services' 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 determinations and subsequent determinations and how often? What's the difference between the Independent Enrollment Broker (IEB) and the Independent Assessment Entity (IAE) for determining eligibility at the start of services?

- A. The Independent Enrollment Broker (IEB) provides choice counseling to CHC participants to assist them in selecting a CHC-MCO and primary care physician (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 Functional Eligibility Determination (FED), which the Department of Human Services uses in determining whether an LTSS applicant is clinically eligible for LTSS.

The Department of Human Services' IAE will be responsible to complete the initial functional eligibility determinations 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 NF clinically eligible even if he or she has not been determined eligible for Social Security Disability/Medicare benefits.

Q32. Will the PCP have any role in functional eligibility determination (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 nursing home or home and community-based long-term services and supports, how will the process change based on implementation of CHC?

- A. Residents of state operated facilities, such as veteran's homes or state long-term care (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 home and community-based waiver services, that individual will be enrolled in CHC if he or she is NF clinically eligible and financially eligible for MA long-term services and supports.

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

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

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 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's computer system using a process that keeps family members enrolled with the same CHC-MCO and otherwise provides for an equal 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 role in assisting the individual with getting enrolled for LTSS?

- A. Service coordinators are responsible to refer individuals to the Independent Enrollment Broker, 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. Service Coordinators and the Independent Enrollment Broker 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 nursing facility residents contact the Independent Enrollment Broker (IEB) to begin the process of enrolling in CHC and describe the enrollment process?

- A. Nursing facility 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 nursing facility residents and come into a nursing facility to provide them choice counseling and enrollment assistance.

Currently, the IEB assists nursing facility 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 nursing facility residents and other LTSS applicants who are applying to receive nursing facility 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 nursing facility residents, the IEB will coordinate and cooperate with the residents' nursing facilities. At a minimum, the IEB will work with the nursing facilities in scheduling visits with and facilitating FED and financial eligibility determination for nursing facility residents. If an LTSS applicant designates a nursing facility as a contact, the IEB will also provide the nursing facility 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.

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 program.

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

- 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 nursing facilities will bill the CHC-MCO for the Medical Assistance 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 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. Ninety percent (90.0%) of clean claims must be adjudicated within thirty (30) days of receipt. One hundred percent (100.0%) of clean claims must be adjudicated within forty-five (45) days of receipt. One hundred percent (100.0%) of all claims must be adjudicated within ninety (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 the Department of Human Services 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 after January 1, 2018. Services prior to January 1, 2018 must be billed to the Department of Human Services via PROMISe™ for reimbursement. Each CHC-MCO will have its own claims 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 January 1, 2018. 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 the Department of Human Services 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 after January 1, 2018.

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

- A. Newly eligible nursing facility 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 nursing facility services provided on and after the residents' CHC enrollment date.

Newly eligible nursing facility residents may also be eligible for retroactive MA coverage of their nursing facility services prior to their enrollment in CHC. Nursing facilities 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-MCO) 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 the day after the eligibility determination date. In this case, the HC-MCO would also be responsible for the nursing facility 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. Nursing facilities (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 nursing facility services. NFs will continue to receive the Pennsylvania Medicaid Long Term Care Application or PA-600L. The CHC-MCOs will review the nursing facility patient pay calculation as submitted on the claim.

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

- A. The Department of Human Services (Department) will continue to use the existing Pennsylvania nursing facility assessment system which allows nursing facilities to submit necessary patient days and the Department 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. The Eligibility Verification System (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. <http://www.dhs.pa.gov/publications/forproviders/QuickTips/>

Q23. Will providers use PROMISe™ after CHC implementation?

- A. Providers must submit claims for services prior to January 1, 2018 to the Department of Human Services via PROMISe™ for reimbursement. Providers must bill the appropriate CHC-MCO to receive reimbursement for services after January 1, 2018 except that: (1) providers will continue to use PROMISe™ for ACT 150 and OBRA waiver participants and (2) nursing facility providers will continue to bill PROMISe™ for nursing facility services provided during the retroactive eligibility period for nursing facility residents.

Q24. Will providers use 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 nursing facility believes that a resident with Medicare is eligible for CHC, what should the facility do?

- A. The nursing facility should contact the Independent Enrollment Broker (IEB) to initiate the Medical Assistance long-term services and supports application process.

Q26. How long will providers have to finish billing for services provided before 12/31/2017?

- A. Providers must submit claims for services rendered to participants in CHC prior to 1/1/2018 following the current timely filing requirements.

Q27. Will changes be made to place of service codes, i.e. nursing facilities 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 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 nursing facilities bill for in-facility respite?

- A. Nursing facilities 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.

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 providers 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 3rd Thursday CHC webinars to help educate providers?

- A. The CHC-MCOs are required to train providers on all aspects of CHC. OLTL anticipates the CHC-MCOs will begin training programs in the fall. Providers should contact the CHC-MCOs to learn about CHC-MCO specific educational opportunities. Regarding the 3rd 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 are currently working with the Department of Human Services on the development and approval of their provider manuals. Providers should contact the CHC-MCOs to learn when provider manuals will be available.

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 the southwest region in July 2017. Similar events will be held in early 2018 for the southeast. Additional information can be found on the CHC website: <http://www.dhs.pa.gov/citizens/communityhealthchoices/>

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-MLTSS@pa.gov. For billing related or contracting questions, providers should contact the CHC-MCO.

Q8. How is a copy of the Third Thursday or MLTSS Sub Committee transcript for the sessions including questions and answers obtained?

- A. Please email RA-PWCHC@pa.gov with the request including the session date.

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 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 Service Coordinators 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.

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 prior to signing contracts?

- A. Nursing facilities 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' requirements outlined in the CHC agreement.

Q9. If my agency is already approved and enrolled through the PA Medical Assistance Program, does my agency also need to go through credentialing with the CHC-MCOs? Will the provider revalidation process through OLTL continue?

- A. All CHC-MCO providers must be enrolled in the PA Medical Assistance Program and must be credentialed by and contracted with a CHC-MCO to receive reimbursement for a CHC participant. The Medical Assistance enrollment process verifies a provider meets Medical Assistance enrollment requirements. This process as well as provider revalidation through the Office of Long-Term Living will continue. Providers must be enrolled in the Medical Assistance program for all types of services they wish to provide under CHC.

Apart from the Medical Assistance 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 the Department of Human Services (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. CHC-MCOs are currently actively contracting with providers in the southwest region.

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. CHC-MCOs are currently actively contracting with providers in the southwest region. 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 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 Continuity of Care 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.

Provider Rates

Q1. Is the CHC-MCO per member per month (PMPM) rate public information?

- A. The Fully-executed CHC agreements will be available on the Pennsylvania Department of Treasury's website, however the rate information will be redacted.

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 such as an increase in 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.

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 for the MA-11 nursing facility cost report?

- A. The Department of Human Services has no planned changes for the MA-11 cost report at this time.

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 1/1/18 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 & 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 currently 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.

Quality and Oversight

Q1. Is there a Paid 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 Paid 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 will include 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.dhs.pa.gov/cs/groups/webcontent/documents/plan/c_250592.pdf

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 <http://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 care manager 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 continuity-of-care period, CHC-MCOs may allow participants to 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. 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 work for more than one CHC-MCO or is it exclusive?

- 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.

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 coordinating 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 services 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, a Pennsylvania-licensed social worker or Pennsylvania-licensed mental health professional) must either: 1) obtain a license within the first year of the start of CHC; 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 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.

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 an 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 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 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.

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 long-term services and supports must be identified in the standardized needs assessment and specified in the participant’s Person-Centered Service Plan.

Assessment Process

Q10. Am I being re-assessed on January 1, 2018 with the new tool?

- A. CHC participants with an existing service plan must receive a comprehensive needs assessment within 180 days of their CHC start date. The comprehensive needs assessment will be performed using Pennsylvania's Individualized Assessment (PIA) tool. Once the comprehensive needs assessment is complete, the participant's person-centered planning team – including their service coordinator 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 PIA 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 PIA tool is used 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 needs assessment and conversations with the participant during the development of the PCSP.

Q12. Does the new PIA tool use an algorithm to determine my hours?

- A. No. The PIA 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 PIA tool will impact authorization of services in a participant's person-centered service plan, but the PIA tool does not assign specific hour allotments using an algorithm.

Q13. Was the PIA tool tested on participants?

- A. Yes. The PIA tool is used for home and community-based waiver programs service planning in many states.

Q14. How are assessors being trained on the PIA tool?

- A. CHC-MCOs will ensure that service coordinators are trained on the PIA tool.

Person-Centered Service Plan (PCSP)

Q15. Will the person-centered service planning 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 long-term services and supports 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 comprehensive needs assessment 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 service coordinator?

- A. CHC does not change a participant’s ability to request a new service coordinator.

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, the participant’s enrollment in the new plan will take effect depending 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. Service coordinators 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.

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).

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 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 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 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, and assisting individuals to choose a CHC-MCO and enroll in a CHC-MCO.

The IEB is 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 are 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 long-term care (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 care and LTSS of their enrolled participants. The Department of Human Services pays the MCO a monthly premium and the MCO provides healthcare coordination and coverage.

10. **Question:** If an adult is in a nursing facility, can they remain there after choosing an MCO?

Revised Response May 1, 2018: If a CHC participant is a resident of a nursing facility on the date CHC is implemented in the CHC zone, the participant will be permitted to continue receiving care at that nursing facility until the participant either leaves the facility or is disenrolled from CHC, or the facility is no longer a Medicaid enrolled nursing facility provider. *Please refer to Q8, Q10, Q20 and Q28 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 nursing facility?

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 one 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 will coordinate long-term services and supports, physical health services and work with the behavioral health MCOs and Medicare. The service coordinator 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
- PA Health & Wellness www.PAHealthWellness.com
- 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 the Department 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 behavioral health services through the state's Behavioral HealthChoices Program, your services will not be impacted by CHC.

If you are not currently receiving your behavioral health 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 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. Is she eligible for CHC?
Response: In general, people with intellectual/developmental disabilities (ID/DD) who receive services through the Office of Developmental Programs (ODP) are not eligible for the CHC Program. If she is nursing facility clinically eligible 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 primary care physician 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 physical health 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 are the long-term supports and services covered for 180-days of transition and the physical health for only 60 days?
Response: The 60-day continuity of care period for physical health 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 long-term services and supports, the continuity of care 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 service coordinator?
Revised Response May 1, 2018: No. Participants will be able to choose between at least two service coordinators 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: Since the program is being rolled out only in the SW, will providers outside of this area participate in January?

Response: Providers outside of the SW zone can contract with the CHC-MCOs to provide services to participants living in the SW zone. Participants should contact the 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 long-term services and supports and physical health providers when choosing their CHC-MCO. After the applicable continuity-of-care period, participants will receive their physical health 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 nursing facility on the day that CHC begins in that zone, she will be able to stay in that nursing facility for as long as she remains CHC eligible and chooses to stay there no matter which MCO she chooses.

A participant should consider both long-term services and supports and physical health 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. Participants should contact a representative from the independent enrollment broker 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**
Response:
- 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**
Response:
- 39. Question:** Is the LIFE program the same thing as UPMC for Life Dual?
Revised Response: No. The LIFE Program (Living Independence for the Elderly) is a different managed care program than UPMC for Life Dual. LIFE is a capitated long-term services and supports program for qualifying people over the age of 55. More information on the LIFE Program can be found at <http://www.dhs.pa.gov/citizens/alternativestonursinghomes/lifelivingindependencefortheelderly/>. 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 long-term services and supports. If you lose your Medicare, are Medicaid-eligible but do not need long-term services and supports, 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 nursing facility clinically eligible. While the department 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 the Complaints and Grievances section of this document for more information.*

44. Question: When will we know all of the homecare organizations 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 Department of Human Services (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 a tool designated by DHS. 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 Community HealthChoices?

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 service coordinators visit nursing homes?

Response: All CHC participants receiving long-term services and supports, whether they are in a nursing facility or the community, will have a service coordinator. CHC-MCOs and nursing facilities are discussing how to coordinate the visits.

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