Community HealthChoices

Direct Service Provider Module

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# CHC Direct Service Provider

## Welcome

Welcome to Community HealthChoices direct service provider training.

## Overview

The Department of Human Services developed this training for home and community-based services (HCBS) direct service providers. If you have not had a chance to complete the Community HealthChoices Overview online module, please do so. The overview module focuses on the Community HealthChoices (CHC) program’s goals and benefits from the participant and stakeholder standpoint. Those elements are essential to your ability to prepare for and work within a managed care approach.

## Course Objectives

In this training, we’ll focus on the roles of providers in CHC, the needs assessment process, the person-centered service plan, the quality standards in CHC, and participant safety.

## Resources

Many resources and website links are mentioned in this module. To ensure they remain accurate, we have placed them in a separate document on this website.

Whenever a link or resource is available in the CHC Resources document, a bar will be displayed at the bottom of your screen.

# CHC Key Concepts

Before we dive in, let’s review key concepts of managed care from the CHC Overview module.

## What are CHC’s goals?

The specific goals of the program are to:

* Enhance opportunities for community-based services,
* Strengthen healthcare and long-term service and support delivery systems,
* Allow for new innovations,
* Promote the health, safety, and well-being of enrolled participants, and
* Ensure transparency, accountability, effectiveness, and efficiency of the program.

## Who is included?

The program enrolls adults who are:

* Eligible for both Medicare and Medicaid, or
* Currently living in a nursing facility paid for by Medicaid, or
* Nursing facility clinically eligible (NFCE) and choosing not to enroll in the Living Independence for the Elderly (LIFE) program.

## Who are the MCOs?

There are three CHC managed care organizations in Pennsylvania:

* AmeriHealth Caritas, which goes by Keystone First in the Southeast,
* Pennsylvania Health & Wellness and
* UPMC Community HealthChoices.

All eligible individuals are asked to select one of the three MCOs when they enroll into CHC.

## MCO Selection & Network Adequacy

Each MCO is accountable for having an adequate network of providers. This means that MCOs must contract with enough providers to meet the needs of all program participants.

## Provider Enrollment and Contracting

What is the process to enroll with the MCOs?

First, providers must be enrolled with Medicaid for all services that they wish to provide under CHC. Next, providers contract with MCOs. If your organization has not already contracted with one or more MCOs, contact the MCOs to start the contracting process. Please note that MCOs must be enrolled with Medicaid as well.

The CHC Resources document has contact information, emails, and websites for the MCOs.

# Participant Enrollment

You might be wondering who is able to enroll into CHC. We’ll look at that next.

## Who enrolls in CHC?

The following individuals can enroll in CHC.

Individuals who are 21 years old and over, are enrolled in CHC if they are:

* Dual-Eligible Participants – These are individuals enrolled in both Medicare and Medicaid (MA), or
* Participants needing LTSS – These are individuals who qualify for Medicaid long-term services and supports due to a need for the level of care provided by a nursing facility. Participants may receive Home and Community-Based Services (HCBS) at home or in the community or reside in a nursing facility. They may also be enrolled in both Medicare and Medicaid (MA).

Eligible individuals aged 55 and older may choose to enroll in CHC or enroll in the Living Independence for the Elderly (LIFE) program. The LIFE program features a managed care approach as well.

## LIFE

The LIFE program is a capitated managed care model that fully integrates comprehensive LTSS, behavioral health, and physical health services to Medicare or Medicaid participants.

To be eligible for LIFE, you must:

* Be age 55 or older,
* Nursing facility clinically eligible,
* Meet the financial requirements as determined by your local County Assistance Office or be able to privately pay,
* Live in an area served by LIFE, and
* Be able to be served safely in the community.

The program is based on a national program called the Program of All-Inclusive Care for the Elderly. The program focuses on individuals living independently in their home and communities for as long as possible. LIFE is an option for eligible individuals alongside CHC.

## Who is not eligible?

Individuals are NOT eligible for CHC if they are:

* Receiving LTSS in the OBRA waiver and are not nursing facility clinically eligible,
* A person with an intellectual or developmental disability who is receiving services beyond supports coordination through the Department of Human Services’ Office of Developmental Programs, or
* A resident in a state-operated nursing facility, including the state veterans’ homes.

## How do individuals enroll?

So, how do individuals enroll in CHC? Pennsylvania has an Independent Enrollment Broker (IEB) for its LTSS programs. The IEB is an independent organization that walks people through enrolling in CHC and selecting an MCO. The IEB follows up with each person, provides options, and helps with the decision-making process by asking about current providers and preferences.

For example, if a participant really likes their current primary care doctor, they would select an MCO that has that provider in its network. Please note that dual eligible participants can keep their Medicare providers regardless of whether they are in the MCO network or enrolled in Medicaid. Remember, the MCO manages all services and supports by contracting with doctors, therapists, specialists, homecare, and other healthcare providers. The IEB helps participants select an MCO that best fits their needs and preferences in healthcare and homecare providers. Participants may change their MCO at any time.

Now check your understanding by answering these review questions.

## Lesson 1 Knowledge Check

1. True or False? Participants who are enrolled in LIFE may not move to CHC.

Please pause.

The correct answer is False. LIFE participants may opt to stay in the LIFE program or move to CHC.

2. How do participants enroll in CHC?

Contact the MCO

Contact the IEB

Contact the County Assistance Office

Fill out the online form on the DHS website

Please pause.

The correct answer is that participants contact the IEB to enroll in CHC.

3. True or False? Once a participant selects an MCO, the participant cannot change the MCO until the next annual reassessment.

Please pause.

The correct answer is False. Participants can change MCOs at any time. MCOs manage that process.

# Roles and Implementation

So, what is your role during implementation? Let’s talk about that more.

## Provider’s Role

As a provider, you must contract with one or more MCOs to provide services in CHC. Your role is to educate and engage with participants and provide services that are in the type, scope, amount, duration, and frequency as identified on the service authorization form. Providers should also look for communications from both OLTL and the MCOs about CHC.

## Implementation Timeline

Let’s review the timeline from the CHC Overview training.

Since January 2020, CHC has been fully implemented in Pennsylvania. The Southwest zone was first with an implementation date of January 2018, followed by the Southeast zone in January 2019, and finally by the Northwest, Northeast, and Lehigh/Capital zones in January 2020.

## MCO Provider Manual

What about MCOs? MCOs must keep their network providers informed and up-to-date with the latest policy and procedures, as they affect the MA Program. MCOs must develop and maintain a provider manual. The provider manual must be distributed in a manner that is easily accessible to all network providers. MCOs may specifically delegate this responsibility to large providers in its provider contract. The Provider Manual must be updated annually. DHS may grant an exception to this annual requirement upon written request from the MCO provided there are no major changes to the manual.

The MCO must submit its Provider Manual and annual updates to DHS for review and prior approval.

## MCO Training

MCOs must develop and maintain a network of providers that is knowledgeable and experienced in serving and supporting participants in CHC. Training is a key element of meeting these requirements. The MCOs must submit and obtain prior approval from DHS of an annual provider education and training work plan. The work plan must outline its methods to educate and train network providers, including its process for measuring outcomes, tracking schedules, and documenting attendance.

## MCO Training Access

Now, let’s read some areas in which MCOs must conduct training

* Needs screening, comprehensive needs assessment and reassessment, and service planning system and protocols and a description of the provider’s role in service planning and service coordination
* Service coordination and how providers fit into the person-centered planning approach
* Population being served
* Accessibility requirements
* Application of the definition of medically necessary
* Information about Alzheimer’s disease and related dementias
* Identification and referrals for mental health and drug and alcohol/substance abuse services
* Diverse needs of persons with disabilities (e.g., how to work with sign language interpreters)
* Policy against discrimination
* Cultural, linguistic, and disability competency & special needs
* Administrative processes
* Issues identified by provider relations
* Quality management processes and issues
* Process to submit materials to the CHC-MCO for utilization review and Prior Authorization review
* Complaint, grievance, and DHS Fair Hearing and Appeals process
* Performance Improvement Projects (PIP) and how providers benefit
* Dual eligibility for Medicare and Medicaid and coordination of services for eligible participants

## SC Role

Ok, so we’ve covered the provider and MCO roles. What about the service coordinator (SC)?

The basic tasks and goals of service coordination are assisting participants in accessing needed LTSS. The objective of service coordination is support for CHC program participants, specifically those individuals in need of LTSS, and those with unmet needs, in the following ways:

* The identification of needed services through the comprehensive needs assessment process.
* The assurance of appropriate service delivery. Service delivery must support both a participant’s needs and their preferences. This is accomplished through the management of the person-centered planning process and the development and implementation of the participant’s person-centered service plan.
* The coordination of the participant’s long-term care services with all of their other services including those provided by Medicare, Medicaid physical health, and behavioral health.

## What’s Included?

Under CHC, service coordination includes identifying, coordinating, and assisting participants in obtaining access to needed health services and in-home supports, as well as social and housing services needed to help participants live in their communities.

In terms of housing, SCs oversee pre-tenancy and transition services for housing, and assist in obtaining and retaining housing. Pest eradication, a barrier to retaining housing currently, is included in the CHC program.

An SC is the MCO’s designated, accountable point-of-contact for each participant receiving LTSS. This is a benefit to participants and their families. There is a single “one call” approach to all physical, behavioral, and LTSS.

## Needs Assessment Process

Service coordination, planning, and delivery is based on health screenings and the comprehensive needs assessment and reassessments. There are several elements to the process under CHC.

First, let’s look at individuals who are dually eligible for Medicare and Medicaid but do not currently receive long-term services in a facility or through waiver services. Within 90 days of enrollment, MCOs will conduct health screenings of these individuals. If the MCO believes that the individual needs LTSS, the MCO will refer the individual for a functional eligibility determination (FED) if the person is nursing facility clinically eligible, NFCE.

## Comprehensive Needs Assessment

The MCOs will perform comprehensive needs assessments on all participants. The MCOs are required to perform reassessments annually to inform the person-centered service plan.

Participants can request a comprehensive needs assessment based on their self-identifying needs or if they experience a change in condition or environment. MCOs can perform one when their team observes changes in a participant’s needs, conditions, or environment. As always, it is important for participants to take as active a role in the process as possible and work with MCOs and assessors to ensure that all needs and preferences are identified accurately. The assessment process lays the foundation for effective service planning and delivery.

## Person-Centered Service Plan

Once needs are assessed and identified, the MCO is accountable for planning services. Each CHC participant will have a person-centered service plan (PCSP). This plan may include both care management and LTSS. Remember, not all CHC participants need LTSS.

PCSPs must be developed by the SC, the participant, the participant’s representative if applicable, and the person-centered planning team.

The planning team may include providers, caregivers, family members, physical health providers, primary care physicians, specialists, behavioral health providers, direct care workers, and others as needed.

## What About NHT?

What about CHC participants in nursing facilities who want to move into the community?

Nursing home transition (NHT) is an administrative role for the CHC-MCOs. MCOs provide NHT services to participants who reside in nursing facilities and desire to move back to their homes or other community-based settings and cannot do so through the normal discharge process because of identified barriers.

## First Time LTSS Enrollment

What about participants enrolling for the first time to receive LTSS through CHC? The LTSS enrollment process is managed by the IEB.

#### Physician’s Certification

There is a need for a physician’s certification of a medical condition or disability and a physician's determination of level of care.

#### FED

There is a functional assessment to determine whether the applicant meets nursing facility level of care or is nursing facility ineligible. This is called the functional eligibility determination.

#### Financial Eligibility

The County Assistance Office (CAO) determines financial eligibility.

#### Enrollment and Selection

Once an individual meets the eligibility requirements (clinical – including the physician's certification and FED, and financial) the person is enrolled in CHC. The person selects an MCO during the enrollment process. CHC-MCO support starts the day after the participant has been determined to be eligible for the program.

#### Summary

In addition, the IEB will manage intercounty transfers, waiver program transfers, MCO transfers, and disenrollment.

## Providers and Participants

Is the provider role with participants different than in fee-for-service? Not really.

## EVS

The Eligibility Verification System (EVS) is used in CHC. Providers are required to ensure that participants are eligible before rendering services. EVS displays the MCO, plan code information, third party liability, and the participant’s primary care physician. For more information, please reference the CHC Resources document for a link to Provider Quick Tip #11.

## Issue Resolution

Lines of communication for participants in CHC are the same as in other HCBS programs. Participants are encouraged to discuss and resolve issues locally with providers and SCs first. MCOs are required to have complaint and grievance processes that include tracking and reporting. MCOs must support the Medicaid fair hearing process. Participants may call the participant helpline for unresolved issues.

## Communication

PAS and home healthcare providers have the most contact with participants.

Some things you can do for the participant include:

* Encourage them to participate in stakeholder engagements in meetings and online.
* Encourage them to read materials and field questions as you can. Note helpline numbers that they can call for more information.
* Encourage them to make informed decisions and select an MCO based on their personal needs.

## Services beyond PAS and Home Healthcare

MCOs must cover services beyond PAS and home healthcare.

#### PERS

MCOs are required to cover Personal Emergency Response Systems (PERS) for participants who have been assessed to need PERS.

#### Home adaptations

MCOs must cover home modifications for participants who have been assessed to need a home modification if their home meets the criteria.

MCOs can determine their home modification provider networks.

#### Other vendor services

MCOs are required to cover vendor services.

Services include but are not limited to:

* Home-delivered meals
* Vehicle modifications
* Non-medical transportation
* Community transition services
* Assistive technology
* Employment and employment-related services
* Pest eradication
* Specialized medical equipment and supplies

MCOs determine their provider networks. Providers must enroll with Medicaid/MA and contract with MCOs.

#### Participant-directed

Participant-directed services, including Services My Way, are available and MCOs offer the option to participants.

The MCO service coordinators perform the same tasks as they do in fee-for-service:

* Identifying the type, scope, amount, duration, and frequency of services
* Monitoring services to ensure the participant’s health and welfare are effectively maintained
* Monitoring of services to ensure the participant is appropriately managing their direct care workers

#### FMS

Financial Management Services (FMS) is an administrative function of the MCO.

MCO service coordinators work with FMS and the participant to ensure:

* The plan is fulfilled.
* Direct care workers’ pay and time are processed according to regulations.
* The participant’s health and welfare are maintained.

## Lesson 2 Knowledge Check

Now, check your understanding by answering these review questions.

1. True or False? DHS must approve each CHC-MCO’s provider education and training plan.

Please pause.

The correct answer is True. MCOs are required to train providers in a number of subject areas. The plan is part of the initial readiness review. It must be updated and submitted annually.

2. True or False? Providers contact the MCOs to determine if participants are eligible before providing services.

Please pause.

The correct answer is False. Providers use the Eligibility Verification System (EVS) to determine eligibility.

3. True or False? Once providers are enrolled with OLTL, they are automatically available to provide services to CHC participants.

Please pause.

The correct answer is False. Providers must enroll with OLTL for all services that they wish to provide under CHC and they must contract with the MCO.

4. True or False? Providers may not contract with more than one CHC-MCO.

Please pause.

The correct answer is False. Providers may contract with one or more CHC-MCOs.

# Maintaining Standards and Safety

Quality is a key CHC goal. Let’s learn about maintaining standards and safety next.

## Quality

MCOs ensure the quality of service coordination and provider services. Each MCO has a quality plan and quality measures that have been approved by DHS. Quality Management Efficiency Teams (QMETs) continue to monitor providers in the Act 150 Program and OBRA waiver.

In addition to monitoring at the local level, there are national and state metrics to measure quality. At the state level, Pennsylvania will assess:

* Community services,
* Service and care coordination,
* Grievances,
* Appeals,
* Critical incidents,
* Rebalancing among facility-based and community-based settings, and
* Adherence to CMS waiver assurances.

## Incident Management

SCs play a central role in incident management. All CHC providers report incidents using the Enterprise Incident Management (EIM) system. MCOs must develop policies and procedures for providers to contact SCs to investigate incidents and must train providers on the procedures. Reporting suspected abuse, neglect, exploitation, and abandonment to older adult and adult protective services is required in CHC.

## EVV

In addition to learning the MCO’s billing system, Electronic Visit Verification (EVV) has been introduced. Initially, methods for time and work reporting were part of the contract with the MCOs.

EVV is required of all MCOs when providing personal care services (PAS, respite in unlicensed settings, and participant-directed community supports) as well as home healthcare services in the community. EVV is used to verify and record the type of service performed, who performed it, who received it, the date, service location, and beginning and end times. Providers have the option to use the MCO’s EVV system. A provider using its own system must ensure that their system is able to send information to the MCO’s EVV system.

## Handling Disputes

So, what if my provider organization contracts with an MCO and has issues with how things work? Where does my organization go?

Provider contracts are with the MCO, so that is where disputes are resolved.

#### MCO Process

MCOs 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. DHS must approve the process and receives reports on disputes and outcomes.

#### Provider Appeal Committee

Each MCO must establish a Provider Appeal Committee, which providers can use to appeal decisions. At least 25% of the membership of the Committee must be composed of providers and/or peers.

#### Interpretation and Resolution of Provider Contracts

The MCO and the provider must handle the resolution of all issues regarding the interpretation of provider contracts. This process does not involve DHS and provider appeals are not within the jurisdiction of the Department’s Bureau of Hearings and Appeals.

## Lesson 3 Knowledge Check

Now, check your understanding by answering these review questions.

1. True or False? DHS does not monitor quality.

Please pause.

The correct answer is False. CHC-MCOs monitor provider quality and are required to submit quality plans and measures. DHS monitors the MCOs for quality. OLTL QMET teams will continue to monitor the Act 150 Program and OBRA waivers.

2. True or False? Incidents are reported through the Enterprise Incident Management (EIM) system.

Please pause.

The correct answer is True. All incidents are reported in EIM. Additionally, reporting suspected abuse, neglect, exploitation, and abandonment to adult and older adult protective services is a requirement in CHC.

3. True or False? Electronic Visit Verification (EVV) is required for all CHC services.

Please pause.

The correct answer is False. EVV is required for personal care services only, such as PAS, respite in an unlicensed setting, participant-directed community supports, and home healthcare services.

4. True or False? If providers have issues with how things are working with an MCO, they report this to DHS immediately.

Please pause.

The correct answer is False. Disputes are resolved between providers and MCOs, not DHS. Each MCO must have a complaint and issue resolution process approved by DHS.

# Summary and Next Steps

What are the next steps for providers?

## Providers

* First, contact the MCOs to discuss contracting. Each MCO’s contact information is included in the CHC Resources document.
* Participate in stakeholder engagement meetings and events.
* Attend the Medical Assistance Advisory Committee (MAAC) and Managed Long-Term Services and Supports (MLTSS) Subcommittee meetings. Links to the MAAC and MLTSS Subcommittee websites are noted in the CHC Resource document.
* Read and share within your organization any CHC-related information sent to you by DHS.
* Get on the ListServ to keep current with updates about CHC. Directions to access the ListServ are noted in the CHC Resources document.
* Visit the HealthChoices website.

## Final Thoughts

Most importantly, providers play a vital role in assisting participants with understanding and navigating CHC. Staying educated and proactively talking with participants about CHC can help participants and their support systems to make informed choices.

# Congratulations

Congratulations! You have completed this module.

If you have read the contents of the entire module, register your completion of this module by going to the appropriate webpage.

If you are an enrolled provider, go to this [webpage](https://oltl-provider.deringconsulting.com/direct-servie-provider-completion/).

If you are not an enrolled provider, go to this [webpage](https://oltl-provider.deringconsulting.com/not-enrolled-direct-service-provider-completion/).