Community HealthChoices

Service Coordination Module

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# CHC Service Coordination

## Welcome

Welcome to Community HealthChoices Service Coordination training.

## Overview

The Department of Human Services developed this training for home and community-based services (HCBS) service coordinators and service coordination entities operating in managed care for long-term services and supports. 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 service coordinators (SCs) to successfully participate in the managed care approach.

This course will review the role of SCs in CHC, the ongoing role of service coordination, new elements, the person-centered service plan, and next steps for SCs and SCEs.

## 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.

# 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 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. If your SCE has not already contracted with one or more MCOs, they should contact the MCOs to start the contracting process.

# 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.

# Roles and Implementation

So, what is the role of SCs in CHC? We’ll talk more about that next.

## 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.

## Who are the MCOs?

MCOs have specific roles within the CHC program. In addition to being the single point of accountability for services and performing service coordination services as an administrative function of the MCO, MCOs are required to:

* Perform participant assessments and reassessments, including assessments for those who do not currently receive long-term services and supports (LTSS),
* Have an adequate network of facilities and providers,
* Provide training to providers in terms of how to use their billing and monitoring systems, and
* Report to DHS on continuity of care and provider payment outcome measures.
* If you’d like more information about the individual MCOs, the CHC Resources document has their contact information, emails, and websites.

## SC Role

What about service coordination? 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 include a care management plan. The care management plan identifies and addresses how the participant’s physical, cognitive, and behavioral healthcare needs are managed. The care management plan includes specifics of how the MCO will coordinate with the nursing facility, Medicare, Veteran’s services, Behavior Health MCOs, and other insurers and supports.

If the individual’s assessment points to a need for LTSS, the person will have an LTSS plan included in the person-centered service plan.

## LTSS Service Plan

The LTSS service plan is similar to fee-for-service service plans (with a broader scope) in that it will include:

* All LTSS necessary to support the participant in living as independently as possible and remaining as engaged in their community as possible. This includes housing assistance, pest eradication, employment, and community engagement support;
* For needs identified in the comprehensive needs assessment, the interventions to address each need or preference, reasonable long-term and short-term goals, the measurable outcomes to be achieved by the interventions, the anticipated timelines in which to achieve the desired outcomes, and the staff responsible for conducting the interventions and monitoring the outcomes;
* Potential problems that can be anticipated, including risks and how these risks can be minimized to foster the participant’s maximum functioning level of well-being;
* The person(s) and providers responsible for specific interventions or services;
* Participant decisions around self-directed care;
* Communications plan;
* How frequently specific services will be provided;
* How—or if—technology and telecare will be used;
* Participant choice of providers;
* Individualized back-up plans;
* Participant’s available, willing, and able informal support network and services;
* Participant’s need for and plan to access community resources, non-covered services, and other supports, including any reasonable accommodations;
* How to accommodate preferences for leisure activities, hobbies, and community engagement;
* Any other needs or preferences of the participant;
* Participant’s goals for the least restrictive setting possible, if the participant is being discharged or transitioned from an inpatient setting;
* How the MCO will coordinate with the participant’s Medicare, Veterans Benefits, Behavioral Health-MCO, and other health coverage insurers, and other supports; and
* Participant’s employment and educational goals.

## PCSP Details

PCSPs must be completed no more than 30 days from the date that the comprehensive needs assessment or reassessment is completed. PCSPs must be developed by the SC, the participant, the participant’s representative, 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.

Participants may appeal part or all of their service plan as provided through the MCO’s complaint and grievance process, and the DHS fair-hearing process.

## 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.

MCOs must provide NHT activities using appropriately qualified staff, whether employed by the MCO or under contract with the MCO. SCs participate in these activities to ensure continuity of care.

## 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.

## Lesson 1 Knowledge Check

Now, check your understanding by answering these review questions.

1. True or False? Under CHC, SCs are responsible for accessing all behavioral health services.

Please pause.

The correct answer is False. The SC will work with a participant’s behavioral health MCO to coordinate services.

2. True or False? Because it is an administrative function, service coordination must be performed by MCO staff.

Please pause.

The correct answer is False. MCOs may perform this internally or may contract with an existing SCE.

3. True or False? Person-centered service plans are developed by the SC.

Please pause.

The correct answer is False. PCSPs must be developed by the SC, the participant, the participant’s representative, 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.

4. True or False? The SC is the participant’s point of contact for LTSS.

Please pause.

The correct answer is True. Under CHC, an SC is the designated, accountable point-of-contact for each participant receiving long-term care services. This is a benefit to participants and their families. There is a single “one call” approach to all physical health services, behavioral health services, and LTSS.

5. True or False? Nursing home transition coordination can be performed by qualified MCO staff or contracted to an NHT provider.

Please pause.

The correct answer is True. Nursing home transition coordination can be performed by qualified MCO staff or contracted to an NHT provider.

6. Services under CHC include: (Select all that apply.)

Pest eradication

Higher education

Room and board

Housing assistance

Please pause.

The correct answer is that pest eradication and housing assistance are services under CHC.

# 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.

## 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.

## 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 2 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 continue to monitor Act 150 and OBRA.

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.

# Summary and Next Steps

So, in CHC the service coordination role is expanded from what it is in OBRA and Act 150 to include more aspects of health, wellness, and independence, and MCOs may subcontract the function to existing SC organizations.

## Providers

What are the next steps for SCs and SCEs?

* 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, SCs 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/service-coordination-completion/).

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