Provider Training

Introduction to Long-term Care

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# Welcome

# Provider Training – Introduction to Long-term Care

Welcome to the Office of Long-Term Living’s Provider online training. This two-part training educates new waiver/program service providers prior to enrolling as a provider and attending the required one-day classroom course.

## Course Overview

This training contains two modules.

* Module 1: Introduction to Long-term Care and
* Module 2: Provider Responsibilities

This course only relates to OLTL publicly funded programs. It does not apply to programs through other offices.

## Module Overview

Module 1: Introduction to Long-term Care includes the basics of the long-term care network in Pennsylvania, an overview of how individuals enroll for publicly funded services, and how providers enroll to deliver those services.

Module 1 contains four lessons.

* Lesson 1: Long-term Care Overview,
* Lesson 2: OLTL Programs, Funding, & Policies,
* Lesson 3: Participant Enrollment & Service Planning, and
* Lesson 4: The Provider Enrollment Process.

## Objectives

After completing this module, you will be able to:

* Describe the components, roles, and responsibilities of the long-term care network in Pennsylvania including:
  + Managed care organizations
  + Service coordinators
  + Services providers
  + Nursing Home Transition
  + Others

During emergency situations when the Governor issues a disaster emergency declaration, the Office of Long-Term Living (OLTL) may need to make temporary changes to the Community HealthChoices (CHC) and/or OBRA waivers through an Appendix K amendment of each waiver, to allow flexibilities in responding to the emergency. OLTL may also decide to allow similar flexibilities in the Act 150 Program. If OLTL elects to allow temporary flexibilities to a waiver or the Act 150 Program, OLTL will inform providers of the approved changes through a ListServ email or through the CHC-MCOs.

## Additional Objectives

After completing this module, you will be able to:

* Identify the relevant federal agencies and the Commonwealth’s offices and bureaus.
* Describe both the participant and provider enrollment processes.
* Identify programs, services, regulations, policies, and licensing agencies.

## Resources

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

Whenever a link is available in the Resources Document, a bar will be displayed in the training module, usually at the bottom of your screen.

## Training Sponsors

Before we begin the lessons, let’s introduce the sponsors of this training, the PA Department of Human Services, known as DHS and the Office of Long-term Living, known as OLTL.

## DHS

The Department of Human Services’ vision is to see Pennsylvanians living safe, healthy, and independent lives. The mission is to improve the quality of life for Pennsylvania’s individuals and families. DHS promotes opportunities for independence through services and supports while demonstrating accountability for taxpayer resources.

Safety, health, independence, and financial accountability are themes critical for providers to understand. We’ll see these elements of DHS’s mission reflected in the policies, procedures, and requirements that you’ll follow and fulfill as providers.

## OLTL

The Office of Long-Term Living is under the Department of Human Services. OLTL was formed to assist in rebalancing Pennsylvania’s long-term care system and to provide independent living opportunities for those who are older or live with disabilities. OLTL’s purpose is to build and maintain a long-term living system that supports quality of life for older Pennsylvanians and adults with physical disabilities.

OLTL recognizes that the majority of Pennsylvanians will need assistance with daily activities such as bathing, dressing, and meal preparation at some point in their lives due to aging, injury, illness, or disability.

Key take-aways for providers are the concept of rebalancing (to provide everyone with the opportunity to live in the community instead of a facility if they choose) and maintaining a system that supports quality of life. This system includes several types of organizations that must all work together with specific roles and responsibilities.

# Lesson 1: Overview of Long-term Care

Before we get into your specific roles as an OLTL provider, let’s take some time to look at the system as a whole. We’ll start with an overview of long-term care in Pennsylvania, focusing on definitions and key roles.

## Long-term Care Definition

For the purposes of this training, we’ll limit the definition of long-term care to the services and supports that are provided through OLTL programs. In this case, long-term care refers to the services and supports that older adults and individuals with physical disabilities receive to remain independent in the living situation of their choice. Long-term care is also known as long-term services and supports or LTSS.

## ADLs & IADLs

Activities of daily living (ADLs) and instrumental activities of daily living (IADLs) are specific activities identified as necessary to remaining independent.

### Activities of Daily Living (ADLs)

Activities of daily living (ADLs) are daily tasks necessary to remain healthy.

ADLs include:

* Bathing, grooming, hygiene
* Toileting and continence
* Transferring
* Eating
* Dressing
* Walking and ambulating

ADLs are activities that, if not performed, would result in an immediate risk to an individual’s health or safety.

### Instrumental Activities of Daily Living (AIDLs)

Instrumental activities of daily living are tasks necessary to live in the world.

IADLs include such things as:

* Shopping
* Transportation
* Housework
* Making and keeping appointments
* Managing household finances
* Social interaction

IADLs are activities that, if not performed, would result in a risk to an individual’s ability to live independently.

### Why are they important?

It is important to understand these concepts and definitions because they affect people’s eligibility to receive publicly-funded services.

## The Network

Through its network of providers, OLTL administers publicly funded programs to provide services and supports to financially eligible individuals with assessed ADL and IADL needs.

## CMS

Part of the funding for OLTL programs comes from the federal government, so there is federal oversight. The Center for Medicare and Medicaid Services, CMS, administers publicly funded programs to support individuals with long-term care needs. Part of this support is directed to people who choose to live at home.

The programs for people living at home are called Medicaid home and community-based service waivers or HCBS waivers. Waiver programs “waive” the old requirement for people to receive services in facilities. CMS matches state funding and requires states to follow rules and policies to continue receiving funding.

## OLTL

At the state level, OLTL administers the federal/state waiver programs and state-funded programs. The administration of the programs includes meeting federal requirements in key areas.

OLTL:

* Ensures the health and welfare of waiver participants,
* Enrolls providers,
* Approves service plans,
* Oversees provider performance, and
* Ensures the quality of services.

We’ll learn more about OLTL in the next lesson.

## Two Approaches

It takes a network of agencies and providers to make the system work. OLTL has two approaches to managing its network of providers – fee-for-service and managed care.

Each approach allows participants to select service coordinators and providers for their LTSS needs and rely on a separate set of providers for medical and behavioral health needs.

The managed care approach differs from the fee for service approach as participants select a managed care organization to support their physical health, medical, and long-term care needs. A behavioral health managed care organization supports participants’ behavioral health needs.

We’ll refer to both approaches throughout the training because providers may operate under both systems.

## Independent Enrollment Broker (IEB)

Individuals enroll in OLTL programs through the Independent Enrollment Broker, known as the IEB. The IEB manages all of the things that need to happen for a person to receive services through an OLTL program. The IEB s responsible for:

* Managing the processes of determining eligibility,
* Directing individuals to programs,
* Providing choice counseling for MCO selection for CHC,
* Selecting a Service Coordinator for individuals eligible for the Fee-for-Service waiver, and
* Referring ineligible individuals to other resources.

We’ll learn more about these processes in lesson three.

## Participants

Once a person is enrolled in an OLTL waiver or program, the individual is now called a participant. People participate in a waiver program. The term “participant” underscores the change from a medical model, which sees people as “patients,” or from a retail model, which sees people as “consumers.”

Participant choice, involvement, health, safety, and quality of experience are central to waiver programs. All planning, service delivery, and monitoring is done in a person-centered manner.

## Participant Rights & Responsibilities

Participants have specific rights and responsibilities. They have choice in all decision-making, including planning, provider selection, services, where they live, etc. Participants also have responsibilities, including:

* Reporting any changes in household, health status, or financial status,
* Treating care workers with dignity and respect,
* Maintaining a home environment that is safe for care workers, and
* Not engaging in behaviors that put their own safety or the safety of others at risk.

More information on participant rights and responsibilities is in the Participant Information Packet. A link can be found in the Resources Document.

As a reminder, if your organization works under the managed care approach, the managed care organization will have supplemental materials related to participant rights and responsibilities.

## Service Coordination

Service coordination is a service that assists a participant in gaining access to needed waiver services, Medical Assistance state plan services, and other medical, social, educational, and employment services regardless of funding source.

Service coordination includes both person-centered service planning and service plan monitoring.

## Service Coordinator

The service coordinator, known as an SC, assists participants in developing their plan of services and supports. SCs:

* Identify participants’ needs and goals,
* Educate them about options and resources, and
* Discuss risks and mitigation approaches.

SCs do not select services or providers. SCs support participants in decision making. Participants make the decisions related to services and service providers. SCs work with service providers to ensure that all services are delivered in the type, scope, amount, duration, and frequency approved and documented on the plan.

## SCE & MCO

Service coordination is performed by either a service coordination entity, known as an SCE or as an administrative function of a managed care organization, known as an MCO.

At enrollment, participants select an SCE or MCO to provide their service coordination.

OLTL monitors both SCEs and MCOs for quality and compliance.

## Managed Care Organizations

Managed care organizations, known as MCOs, are additions to Pennsylvania’s network of long-term care providers. MCOs perform the service coordination function for participants enrolled in Community HealthChoices, known as CHC. They do this by contracting with SCEs or by hiring service coordinators directly. The difference from the fee-for-service approach is that MCOs coordinate both physical health and long-term care services. They work with behavioral health MCOs as needed.

## How Does It Work?

### Funding

DHS pays a per-member-per-month rate to the MCOs.

This is called a capitated rate.

### Accountability

DHS then holds MCOs accountable for quality outcomes, efficiency, and effectiveness.

The MCOs manage participants’ physical health and long-term care needs.

They coordinate with Medicare, behavioral health organizations, and other funding sources.

### Providers

Service providers, such as physicians, specialists, therapists, homecare, and home healthcare, contract with, are managed by, and are reimbursed by the CHC-MCOs.

## CHC-MCOs

There are three CHC managed care organizations in Pennsylvania:

* AmeriHealth Caritas Pennsylvania Community HealthChoices in the Southwest, Northwest, Northeast, Lehigh/Capital zones and Keystone First Community HealthChoices in the Southeast zone,
* Pennsylvania Health & Wellness, and
* UPMC Community HealthChoices.

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

Each MCO is accountable for having an adequate network of providers.

In addition to enrolling with OLTL, providers must contract with CHC-MCOs. Providers under CHC who contract with MCOs bill the MCO for services.

For more information about the rollout of managed care in your areas, please visit the HealthChoices Provider Resources website. The link can be found in the Resources Document.

## Direct Service Providers

Once a participant has developed a service plan with the Service Coordinator, the next step is for the participant to select providers for the services and supports on the service plan. Direct service providers are those organizations that provide home and community-based services, such as home care, home health care services, home adaptation services, employment services, transportation, and other services to participants.

Participants make the choice. SCs are prohibited from influencing the participant’s choice. If a participant is not aware of any local providers and does not know which they would like, SCs provide a list of enrolled providers in their area.

## Services

Providers provide services as documented in an authorization document from an SCE or MCO. Providers may contract with multiple MCOs and may enroll to provide services through multiple waivers and programs. OLTL and MCOs monitor providers for quality and compliance.

## Billing

Under CHC, providers bill the MCO for services. Under other waivers and programs, providers bill OLTL. Providers can provide services through multiple OLTL waivers and programs.

In order to bill for services, providers must be enrolled with OLTL for specific waiver and services in specific counties. Under the managed care approach, providers must also contract with specific MCOs.

## Nursing Facilities

What does a Nursing Facility have to do with long-term services and supports via home and community-based services? Well, some people in nursing facilities may choose to transition to living in the community. Programs, such as the Nursing Home Transition program, assist people who want to do this. Nursing facilities may also be involved if an individual needs a specific type of care for a period of time and then returns to the community. Service coordinators, nursing home transition coordinators, and MCOs are the organizations most involved in this process.

## Area Agencies on Aging

Area Agencies on Aging, known as AAAs, provide services, supports, and other programs for individuals ages 60 and over. Their services are funded by the PA Department of Aging, known as PDA.

In addition to providing aging-specific services under PDA, some AAAs provide OLTL services. Under OLTL, some AAAs function as service coordination entities or nursing home transition coordinators. AAAs are also involved in Protective Services for individuals age 60 and older.

## Other Agencies

There are other state agencies involved with providing long-term services and supports to adults in Pennsylvania. For example, home care or home health providers, must be licensed by the PA Department of Health and follow all of their rules and regulations. Some transportation providers must be licensed by the Public Utility Commission.

Long-term care services provided to individuals with intellectual disabilities are funded by the Office of Developmental Programs, known as ODP. ODP has its own rules and regulations that you must follow. Providers must comply with all rules from all agencies that affect their work.

## Continuity of Care

Multiple options in planning and providing services are great in terms of participants having choice. The downside is that there exists the potential for mistakes when multiple organizations are involved.

Every provider, including service coordinators, direct service providers, MCOs, and others, must ensure that participants experience continuity of care. This means no interruption in service. To prepare for and handle things going wrong, plans must be in place at the SC, provider, and participant levels. We’ll review this in detail in the next module.

## Working Together

So, who makes sure that all of these organizations work together? The Office of Long-Term Living provides oversite of its programs. Oversight includes provider enrollment, quality management, service plan review, continuity of care, and critical incident management.

Some public programs are funded by the state and the federal government. Because of this, OLTL reports to both.

## Summary

That’s a lot of organizations and agencies. The system is designed to provide the most choice and flexibility for participants while safeguarding their health and safety. It is also designed to ensure that DHS is an effective steward of public funds.

Now check your understanding of what’s been covered so far by answering these review questions.

## Lesson 1 Knowledge Check

1. OLTL administers only state-funded programs.

True

False

Please pause.

The correct answer is False. OLTL administers both federally-funded and state-funded programs.

2. Providers may enroll in multiple waivers and contract with multiple managed care organizations.

True

False

Please pause.

The correct answer is True. Providers may enroll in multiple waivers and contract with multiple managed care organizations.

3. Which of the following are responsibilities of service coordination entities? (Select all that apply.)

Assist participants in developing their plan of service and supports

Educate participants about options and resources

Manage the process of determining eligibility

Discuss risks and approaches

Choose providers on behalf of participants.

Please pause.

The correct answer is that the following are responsibilities of service coordination entities assist participants in developing their plan of services and supports, educate participants about options and resources, and discuss risks and approaches.

The IEB manages the process of determining eligibility.

Service coordination entities may not help participants choose providers. They can provide a list of eligible providers in the participant’s area.

4. Which of the following are considered activities of daily living? (Select all that apply.)

Bathing

Toileting

Housework

Eating

Please pause.

The correct answer is that bathing, toileting, and eating are all activities of daily living that are necessary to remain healthy.

5. Managed care organizations: (Select all that apply.)

Selet the providers they want in their network

Manage the process of initial enrollment

Manage participant’s physical health and long-term care services

Pay providers for CHC services

Please pause.

The correct answer is that managed care organizations select the providers they want in their network, manage participant’s physical health and long-term care services, and pay providers for CHC services.

6. If a service provider enrolls with OLTL, there is no need to contract separately with an MCO.

True

False

Please pause.

The correct answer is False. Providers must enroll with OLTL and contract with managed care organizations.

7. Service providers bill OLTL for all programs and waiver services rendered.

True

False

Please pause.

The correct answer is False. Under CHC, providers bill the MCO for services rendered.

# Lesson 2: DHS & OLTL: Structure & Programs

Ok, let’s take a closer look at the DHS structure and OLTL bureaus and programs.

## DHS Structure

The Department of Human Services has a total of eight different program offices. As an adult services provider, you may work with the following five key offices:

* The Office of Developmental Programs supports programs for individuals with intellectual and developmental disabilities.
* The Office of Income Maintenance provides oversight of several programs that affect long-term care, including Medicaid, Supplemental Nutrition Assistance Program, heating assistance, employment, and others.
* The Office of Medical Assistance Programs administers the federally and state-funded Medicaid program through its County Assistance Offices.
* The Office of Mental Health and Substance Abuse Services supports programs for individuals with conditions related to behavioral health and substance abuse.
* The Office of Long-Term Living administers programs for adults with long-term care needs.

## OLTL Structure

This training focuses on your role as an OLTL provider. There are six bureaus within OLTL:

* The Bureau of Fee-For-Service Programs
* The Bureau of Coordinated and Integrated Services
* The Bureau of Policy Development and Communications Management
* The Bureau of Finance
* The Bureau of Quality Assurance and Program Analytics
* The Bureau of Human Services Licensing

## OLTL Bureaus

### Bureau of Fee-For-Service Programs

The Bureau of Fee-For-Service Programs manages provider focused activities and functions in OLTL. The bureau is responsible for:

* MA provider enrollment activities under provider type 03, provider type 07, and provider type 59 in coordination with the Office of Medical Assistance Programs.
* Claims management in fee-for-service (FFS) programs, such as Act 150, as well as other waiver programs.
* Managing the financial management contract, which provides payroll assistance to participants of the self-directed model of care.
* Directing the Quality Management Efficiency Teams (QMETs) that audit and analyze the quality and efficiency of services delivered by providers who participate in OLTL waivers and Community HealthChoices (CHC) to ensure compliance with state and federal regulations.
* Reviewing and approving new and amended service plans for OLTL’s FFS waiver/programs and providing technical assistance to Service Coordinators and providers for participants receiving home and community-based services (HCBS) through OLTL’s FFS waiver/programs.

This bureau has two divisions:

* Division of Provider Operations
* Division of Fee-For-Service Operations

### Bureau of Coordinated and Integrated Services

The Bureau of Coordinated and Integrated Services is responsible for the administration and oversight of the Community HealthChoices managed care organizations (CHC-MCOs) that provide managed long-term services and supports to eligible participants. The bureau is also responsible for the development and management of the Living Independence for the Elderly (LIFE) managed care program.

The bureau:

* Assesses changes in state or federal regulations to identify the impact on the CHC-MCOs, the LIFE program, and their agreements
* Negotiates agreements with managed care organizations and contracts with other vendors that support bureau functions
* Imposes program sanctions and penalties, where appropriate
* Directs corrective action plans for CHC-MCOs and other contractors

This bureau has three divisions.

* Division of Participant Supports
* Division of Monitoring and Compliance
* Division of Integrated Care Programs

### Bureau of Policy Development and Communications Management

The Bureau of Policy Development and Communication Management supports the strategic policy and communication goals across all bureaus and OLTL’s Deputy Secretary’s Office.

The bureau:

* Plans, coordinates, evaluates, and develops policies and procedures across OLTL, and coordinates internal and external communication with stakeholders
* Serves as a liaison with other DHS programs and policy offices and other commonwealth agencies
* Supports all bureaus in the development of consistent policy, evaluating impact, and improving strategic directions
* Serves as the liaison with DHS’s right-to-know law office
* Coordinates the submission of the state plan amendments, home and community-based waivers, and other program documents to the federal government
* Coordinates changes to the Community HealthChoices Agreement

This bureau has three divisions.

* Division of Policy Development and Analysis
* Division of Communications Management
* Division of Community Living Program Initiatives

### Bureau of Finance

The Bureau of Finance manages and monitors OLTL’s appropriations and operating budget of approximately $7 billion.

The bureau:

* Serves as liaison to the DHS budget office and the Governor’s budget office
* Develops and manages managed care and fee-for-service related fiscal activities including:
  + Rate setting
  + Cost reporting
  + Budget reporting and submissions
  + Audits
  + Fiscal management of grants and contracts

This bureau has two divisions.

* Division of Budget Development and Operations
* Division of Rate Setting and Auditing

### Bureau of Quality Assurance and Program Analytics

The Bureau of Quality Assurance and Program Analytics is responsible for ensuring that valid statistical and procedural methodologies are used to collect and analyze quality control data to evaluate and improve service delivery and to ensure compliance with federal and state regulations.

The bureau:

* Manages data analysis to measure the effectiveness of program design and operations, and ensures required reports are provided to CMS and other regulatory entities
* Manages and coordinates the ventilator dependent and durable medical equipment exception programs
* Supports OLTL management in the development and implementation of policies and procedures
* Directs the development and implementation of internal and external training to improve service delivery
* Oversees the analysis of data obtained through consumer satisfaction surveys and provider performance measures
* Oversees internal and external activities of OLTL Monthly Quality and Quarterly Quality Review meetings reviewing waiver assurances

This bureau has two divisions.

* Division of Quality Assurance
* Division of Program Analytics

### Bureau of Human Services Licensing

The Bureau of Human Services Licensing is responsible for the overall management and coordination of Personal Care Home and Assisted Living Residences licensing programs administered by the Department of Human Services (department) in the Central, Northeast, Southeast and Western regions. Responsibilities include the management, planning, direction, oversight, design, development, and administration of licensing statutes, licensing regulations and policy, licensing enforcement policy, licensing training, licensing research, and licensing data systems for more than 1,100 out-of-home care settings licensed by the department serving over 67,000 adults with mental illness, developmental disabilities, physical disabilities, behavioral, and/or cognitive disorders.

This bureau has five divisions:

* Division of Regulatory Implementation
* Division of Professional Development
* Division of Licensing Administration
* Division of Licensing Operations
* Division of Adult Protective Services

## Provider Assistance

You can call for assistance Monday through Friday from 9am to 4pm using the toll-free number in the Resources Document. The toll-free line is available to assist you with enrollment, billing, and other issues.

As a reminder, under CHC, if you have a billing or payment issue, contact the appropriate CHC-MCO.

## Participant Helpline

All providers must be aware of the Participant Helpline. The helpline is for waiver participants to use for any reason such as if they are dissatisfied, are not receiving services, or have concerns. The Participant Helpline is a point of escalation for participants and people applying for waiver services. The helpline number can be found in the Resources Document.

## OLTL Programs

Now that you’re familiar with OLTL’s structure and “who to call,” let’s look at OLTL waiver and state-funded programs.

Waiver programs offer long-term services and supports that are not included under health insurance programs. Waiver programs are funded by federal and state dollars. Waiver programs must always be payers of last resort. There can be no duplication of funding or services. All other funding sources (such as private insurance, Medicare, veteran’s benefits, settlements, and others) must be accessed and exhausted before waiver funding can be applied.

## OLTL Program Specifics

### CHC

Community HealthChoices is for individuals ages 21 and over who have been assessed to require services at the level of nursing facility level of care or who are dually eligible for Medicare and Medicaid services.

CHC features the use of managed care organizations to coordinate physical health and long-term care needs.

CHC service plan documentation is housed in each individual MCO’s systems.

Providers bill the individual CHC-MCO for services under this program.

MCOs monitor providers for compliance and provide OLTL with compliance reports.

Please note that the OLTL Aging Waiver, Attendant Care Waiver and Independence Waiver were transitioned to the CHC Waiver effective 12/31/19.

### OBRA Waiver

The OBRA Waiver is for individuals ages 18 to 59 who have a severe developmental physical disability requiring an Intermediate Care Facility/Other Related Conditions (ICF/ORC) level of care.

Service plan documentation is housed in OLTL’s systems.

Providers bill OLTL for services under this waiver.

OLTL monitors providers for compliance.

### Act 150

The Act 150 Program is a state-funded program for individuals ages 18 to 59 who have been assessed to require services at the level of nursing facility level of care.

This program is for individuals who do not financially qualify for waiver. It may assess a minimum copayment for services.

Service plan documentation is housed in OLTL’s systems.

Providers bill OLTL for services under this waiver.

OLTL monitors for compliance.

### LIFE

The Living Independently for the Elderly (LIFE) program is for individuals ages 55 and older.

LIFE is a managed care program that provides a comprehensive all-inclusive package of medical and supportive services.

The program is known nationally as the Program of All-Inclusive Care for the Elderly (PACE).

All of the PACE providers in Pennsylvania have the name “LIFE” in their name.

Documentation is housed with LIFE providers.

Providers bill OLTL for services. OLTL monitors providers for compliance.

### Summary

Each waiver has specific rules and requirements associated with it.

All providers are encouraged to read the waiver’s documentation to ensure that they are in compliance with its specifics, especially in terms of service definitions (found in Appendix C of each waiver document) and care worker requirements.

The links to all waiver and program documentation can be found in the Resources Document.

## Regulations and Policies

In addition to specific waiver and program regulations, providers must comply with all federal and state regulations and policies. This training will direct you to the regulations and policies that affect you as an OLTL provider. Please note that you must also follow policies of other licensing agencies, such as the Department of Health.

### Federal Regulations

The Centers for Medicare and Medicaid Services publish federal regulations specific to HCBS waiver programs in the Code of Federal Regulations. It is divided into 50 titles that represent broad areas subject to federal regulation. Title 42 is the Public Health section.

All OLTL providers must comply with applicable federal regulations contained in the Code of Federal Regulations. The code is available online.

### PA Code

All providers must comply with applicable state regulations contained in the Pennsylvania Code. Providers should familiarize themselves with these regulations and establish policies and procedures in their organizations to ensure compliance. The code is available online.

The Chapters that apply to OLTL providers include but are not limited to:

55 Pa Code

* Chapter 20 Licensure or Approval of Facilities and Agencies
* Chapter 52 Long-Term Living HCBS
* Chapter 41 MA Provider Appeal Procedures
* Chapter 275 Appeal and Fair Hearing and Administrative Disqualification Hearings
* Chapter 1101 General Provisions
* Chapter 1150 General Payment Provision
* Chapter 2380 Adult Training Facilities
* Chapter 2390 Vocational Facilities
* Chapter 2600 Personal Care Homes
* Chapter 2800 Assisted Living Residences

6 Pa Code (PA Department of Aging)

* Chapter 11 Older Adult Daily Living Centers

28 Pa Code (PA Department of Health)

* Chapter 601 Home Health Care Agencies
* Chapter 611 Home Care Agencies and Home Care Registries

### OLTL & OMAP Policies and Directives

DHS issues bulletins and directives that apply to providers of home and community-based services.

These documents contain operating procedures, clarifications, and explanations of existing regulations.

All providers must comply with all policies and procedures.

### LISTSERVs

New bulletins are issued through multiple LISTSERVs. OLTL LISTSERVs include:

* Service coordination entities
* OLTL providers
* Nursing facilities
* LIFE providers
* Nursing home transition partners
* Community HealthChoices

Multiple provider staff members may be on a LISTSERV to receive updates via email.

OLTL requests that providers sign up for any LISTSERVs that will impact their area of business and ensure that providers keep email addresses updated. If your organization has difficulty signing up, contact the Enrollment section for assistance.

The directions for signing up for a LISTSERV can be found in the Resources Document.

### DHS Website

All bulletins and publications are posted to the DHS website. You can do a search to find policies on specific topics.

You can access and search:

* Bulletins
* Forms
* Waivers

The directions to do this can be found in the Resources Document.

## Summary

All of these rules support the CMS and DHS mission to help participants live as independently as they choose and as safely as possible by providing high quality, cost-effective services, and supports. All providers must follow all federal, state, and program office rules, regulations, and policies. Providers can be sanctioned or have their provider agreement terminated if they do not follow these.

Now check your understanding of what’s been covered so far by answering these review questions.

## Lesson 2 Knowledge Check

1. Providers must comply with all federal and state regulations and policies.

True

False

Please pause.

The correct answer is True. Providers must comply with all federal and state regulations and policies.

2. Bulletins, forms, waiver, and program information can be found on DHS’s website.

True

False

Please pause.

The correct answer is True. You can do a search for bulletins, forms, waiver, and program information on DHS’s website.

3. Only one provider staff member may be on a LISTSERV to receive updates via email.

True

False

Please pause.

The correct answer is False. Multiple provider staff members may be on a LISTSERV to receive updates via email.

Providers are encouraged to sign up for LISTSERVs and to keep their email addresses updated.

4. Which of the following are true statements about OLTL programs? (Select all that apply.)

Offer long-term services and supports that are not included under health insurance programs

Must be payers of last resort

Are funded only by the state

Do not pay for services provided through managed care organizations

Please pause.

The correct answer is that OLTL programs offer long-term services and supports that are not included under health insurance programs and must be payer’s of last resort.

Waiver programs are both federally-funded and state-funded.

The Community HealthChoices program uses managed care organizations to coordinate physical health and long-term care services for participants.

# Lesson 3: Participant Enrollment

Let’s take a look at how individuals become waiver or program participants. The process is called “enrollment” and takes several steps.

## Independent Enrollment Broker (IEB)

The IEB manages the enrollment process. The process has three tasks or steps: participants must be functionally eligible, financially eligible, and programmatically eligible. The target timeframe for enrollment is 60 days. However, the IEB has 90 days to complete enrollment. There may be certain challenges that may extend the timeframe.

## IEB Tasks

The enrollment process has three tasks or steps.

Participants must be:

* Functionally eligible
* Financially eligible
* Programmatically eligible

### Functional

A physician must certify that the participant has a medical condition that results in a need for long-term services and supports.

The certification is not enough to guarantee enrollment or to guarantee a certain number of hours of support.

Having a diagnosed disability is not enough to be functionally eligible. The disability must result in a person’s inability to perform activities of daily living.

For example: If a man has a traumatic brain injury, the injury must prevent him from bathing, toileting, transferring, or performing other ADLs for him to be functionally eligible.

At the request of the IEB, a specially trained assessor completes the functional eligibility determination.

### Financial

To receive publicly funded services, individuals must meet income and/or asset requirements.

The local County Assistance Office (CAO) determines financial eligibility.

The participant must complete forms and provide financial documentation.

### Program

Another step is determining which program provides the best fit for the participant based on their medical and functional determinations.

The IEB directs individuals to programs for which they are eligible.

### Summary

If individuals are functionally, financially, and programmatically eligible, they are enrolled in a program.

If individuals do not meet requirements, the IEB refers them to other programs and avenues of support.

## Challenges

This process may seem daunting to some individuals. Often, providers may want to help. This is not the preferred method. A provider “helping” with enrollment support may be seen as exerting undue influence over the participant or “gifting” time in the expectation that the participant will be obligated to choose the organization. Both of these situations violate provider agreements. So, where can you send people who need help with enrollment?

## PA Link

There is a separate program in Pennsylvania to help – the PA Link to Aging and Disability Resources, known as the PA Link. Part of the mission of the PA Link is to “streamline access to public programs.” This is a federal requirement. The PA Link has counselors available to assist individuals with waiver and other program enrollment paperwork. It is what they do. You can also help people find interim services during the enrollment process. Contact information for the PA Link can be found in the Resources Document.

## Starting Planning

OK, so let’s assume that a person has successfully enrolled. What’s next?

If enrolled in CHC, the participant selects an MCO. For other programs, the participant selects a service coordination entity. The IEB sends the enrollment documents to the MCO or SCE. For participants enrolled in CHC, the MCO has five business days to complete a needs assessment and an additional 30 days to develop and approve the service plan. For other programs, the SCE has two business days to contact the participant to start the planning process and 15 business days to complete a service plan to submit to OLTL for approval. OLTL reviews the plan and notifies the SCE of its approval. SCs review waiver participants’ rights and responsibilities with the participant.

## Starting Services

As part of the planning process, the participant selects their choice or choices of direct service providers to deliver services. SCs contact the service providers to see if they can accept the participant. When the plan is approved, the service coordinator sends an authorization to the provider. The authorization includes the type, scope, amount, duration, and frequency of the services to be provided. Services must be provided based on the specifics in the authorization.

If providers have questions or find inaccurate information on the authorization, they should contact the SC for clarification and request a corrected authorization. SCs must send an updated authorization to the direct service provider.

## Freedom of Choice

Throughout all of these processes, participants have the freedom to:

* Select an institutional or community-based setting to receive services
* Choose among programs for which they are eligible
* Choose among enrolled and available providers by completing the participant choice forms
* Request an assignment or change in SC, SCE, direct service provider, or MCO
* Participate in decisions related to services and the service plan

All services and supports must be provided in a person-centered manner.

## Summary

This is an overview of complex processes. For more detail about the enrollment and service planning process, check out the Resources Document.

Now check your understanding of what’s been covered so far by answering these review questions.

## Lesson 3 Knowledge Check

1. The independent enrollment broker determines a participant’s financial eligibility.

True

False

Please pause.

The correct answer is False. The independent enrollment broker manages the enrollment process but the County Assistance Office (CAO) determines participants’ financial eligibility.

2. Part of enrollment in Community HealthChoices is for the participant to select an MCO.

True

False

Please pause.

The correct answer is True. Part of enrollment in Community HealthChoices is for the participant to select an MCO.

The MCO performs the service coordination duties.

3. Throughout the process, participants have the freedom to: (Select all that apply.)

Select an institutional or community-based setting to receive services

Participate in decisions related to services and the service plan

Choose among any OLTL programs

Choose among enrolled and available providers by completing the participant choice forms

Please pause.

The correct answer is that throughout the process, participants have the freedom to select an institutional or community-based setting to receive services, participate in decisions related to services and the service plan, and choose among available providers by completing the participant choice forms.

Participants may choose among OLTL programs for which they are eligible.

# Lesson 4: Provider Enrollment

Now you know how participants enroll. Let’s talk about how you enroll as a provider.

## Enrollment Instructions

All providers must enroll with OLTL. In addition, if your organization plans to provide services under CHC, you must contract with individual MCOs to provide services to CHC participants. We’ll hit the highlights in this training so you know what to expect.

Documents, instructions, and information for provider enrollment can be found on the Department’s Enrollment Information website. The directions to access the website can be found in the Resources Document.

## Provider Enrollment Overview

### Enrollment

#### Access DHS Website

First, access, review, and complete enrollment forms and information on the DHS website. If you have questions, contact OLTL.

#### Enroll all service locations

Keep in mind that providers must enroll all service locations with OLTL.

A service location is a physical location of your business. It is typically defined as where services are provided, people go to work, or employees drop off time sheets.

Be prepared to review your service locations related to the list of counties in which you plan to provide service.

#### Provide information

OLTL requests the following information.

* OLTL-HCBS Waiver Checklist
* The Pennsylvania PROMISe™ Provider Enrollment Base Application
* Provider Ownership and Controlling Interest Disclosure Form
* OMAP-Provider Agreement for Outpatient Providers
* OLTL-HCBS Waiver Agreement
* OLTL-HCBS Provider Enrollment Information Form
* Copy of an IRS generated letter containing the Provider’s FEIN with current IRS address
* Applicable state certification or licensure
* Most Recent Tax Return
* Most Recent Balance Sheet
* Policies that are in compliance with 55 Pa. Code § 52.11
* Other important information such as resumes, diplomas, copies of owners’ social security cards, copies of liability insurances, and provider’s job descriptions of services selected.

#### Follow-up

Providers who do not qualify or have an incomplete application packet are notified. Providers have 15 days to submit any requested information.

### Notifications

#### Notifications

Once you are approved and enrolled, you will receive two notifications.

* An autogenerated letter from PROMISe™
* Notification from Enrollment

#### Letter from PROMISe™

PROMISe™ is OLTL’s system that you use to bill OLTL for services.

The autogenerated letter from PROMISe™ includes your Provider ID and revalidation date.

Note and document your Provider ID. You will use the ID when calling for assistance.

#### Notification from Enrollment

Check the notification you receive from Enrollment to ensure that all service locations, services, and other specifics are accurate and complete.

If they are not, contact the Enrollment section for assistance.

Note: Providers are expected to be able to immediately deliver services in the counties in which they enroll. This often requires providers to review their staffing levels in the enrolled counties.

### Requirements

#### Fulfill all requirements

You must be enrolled accurately and meet all requirements prior to delivering services.

#### Fee-for-service

For example, to deliver personal assistance services under fee-for-service, you must:

* Fulfill the Department of Health’s licensing requirements (You are responsible for maintaining the current status of your applicable license.)
* Enroll with OLTL

#### CHC

For example, to deliver personal assistance services under CHC, you must:

* Fulfill the Department of Health’s licensing requirements (You are responsible for maintaining the current status of your applicable license.)
* Enroll with OLTL
* Contract directly with MCOs (You should contact the MCO.)

### Ongoing Enrollment/ACA

#### Revalidate service locations

Under the Affordable Care Act, Medicaid providers are required to revalidate all service locations every five years.

#### Pay enrollment fees

Enrollment fees are required of Medicare providers and are paid directly to Medicare.

There is also an enrollment fee associated with OLTL providers with specialties 050 and 250 that are paid directly to PA Medicaid.

#### Provide information

For all board of directors, managing employees, and owners with 5% or more controlling interest, providers are required to provide:

* Social security numbers
* Dates of birth
* Residential addresses

#### DHS responsibilities

DHS must:

* Conduct exclusion screenings of board members, owners, controlling interests, agents, and managing employees
* Ensure criminal background checks are performed on all provider employees
* Conduct cross-state screenings for out-of-state providers
* Track provider license status

For more information, visit the DHS website provider section and select Affordable Care Act - Provider Information.

### Enrollment Changes

#### New Owner – New provider assignment

A new Provider Agreement must be executed if a new owner wants to do business under a different federal EIN.

A new ownership and disclosure form is needed if the new owner wants to do business under an existing federal EIN.

Transfer can only occur if:

* Applicable state and federal statutes and regulations are satisfied
* The buyer has been determined to be eligible to participate as an OLTL provider of services

#### New Owner – Report to OLTL

Providers must report a change in ownership or controlling interest of five percent (5%) or more to OLTL:

* At least 30 days prior to the effective date of change
* No later than two business days after the effective date with an explanation

#### Location/Services Changes – Provider status

Providers must notify OLTL/Enrollment and change their documented provider status 30 days in advance when:

* Counties, services, or waivers are added and/or changed
* Service locations are changed or added
* Emails, site addresses, or phone numbers are added or changed

#### Location/Services Changes – Licensure

Providers must notify OLTL when there is any change in their licensure’s status.

#### Documentation

Providers should work with Enrollment to ensure changes are accurately documented. Failure to submit a complete and accurate report constitutes a deceptive practice and justifies termination of the Provider Agreement by OLTL.

Providers may need to complete a new PROMISe™ Provider Enrollment Base Application depending on the extent of changes. If you are unsure or need assistance, please talk with the Enrollment section.

### Information Changes

#### ePEAP

“What about when my contact information changes and everything else is the same? Do I need to get OLTL involved for a minor change?” No. Minor changes can be made through ePEAP.

Electronic Provider Enrollment Automation Project (ePEAP) allows enrolled Providers to request changes to their Provider information electronically. It is accessible from the PROMISe™ main page.

#### Allowed changes

Providers may change the following information through ePEAP:

* Phone/Fax Number
* Email Address
* Mail to Address
* Pay to Address

#### Service location address change

Providers CANNOT update their service location address in ePEAP.

Service location address changes must be added using the address change form and must be accompanied with an updated license.

## Summary

Enrolling as an OLTL provider has multiple steps. Licensures come first, then the checklist of business information, then the documentation package is sent to OLTL. The Enrollment section is there to help you navigate the process. When you are enrolled, remember to keep your Provider ID handy for technical support and keep your licensure and business information up to date with OLTL.

Now check your understanding of what’s been covered so far by answering these review questions.

## Lesson 4 Knowledge Check

1. All providers must contract with all MCOs.

True

False

Please pause.

The correct answer is False. All providers must enroll with OLTL.

If a provider plans to provide services under Community HealthChoices, then they must contract with individual MCOs.

2. Providers may update their service location address through ePEAP.

True

False

Please pause.

The correct answer is False. Providers cannot update their service location address through ePEAP. Service location address changes must be made using the address change form and must be accompanied with an updated license.

3. Providers must notify OLTL and change their documented provider status 30 days in advance when: (Select all that apply.)

Counties, services, or waivers are added and/or changed

Service locations are changed or added

Emails or phone numbers are added or changed

Licensure’s status changes

Please pause.

The correct answer is that providers must notify OLTL and change their documented provider status 30 days in advance when counties, services, or waivers are added and/or changed; service locations are changed or expanded; and licensure’s status changes.

# Congratulations!

Congratulations! You have completed the first module, Introduction to Long-term Care, in the OLTL Provider Training.

If you are an enrolled provider, go to [this website](https://oltl-provider.deringconsulting.com/enrolled-long-term-care-completion/) to register completion of this module. If you are not an enrolled provider, go to [this website](https://oltl-provider.deringconsulting.com/not-enrolled-long-term-care-completion/) to register completion of this module.

Remember to download the Resources Document for reference and please continue with Module 2.