Community HealthChoices (CHC)

**Implementation:**

**Phase 1** began January 1, 2018. Southwest region (Allegheny, Armstrong, Beaver, Bedford, Blair, Butler, Cambria, Fayette, Greene, Indiana, Lawrence, Somerset, Washington and Westmoreland Counties)

**Phase 2** is scheduled to begin January 1, 2019, Southeast region (Bucks, Chester, Delaware, Montgomery and Philadelphia Counties)

**Phase 3** is scheduled to begin January 1, 2020, remainder of the state.

Selected CHC-MCO plans for all three Phases are: AmeriHealth Caritas/Keystone First, Pennsylvania Health and Wellness (Centene) and UPMC Community Health Choices.

**Reimbursement Q & As:**

1. **Question:** How will the rates be established for the nursing facilities under CHC- MCO?

   **Answer:** The fee-for-service (FFS) payment system for nursing facility services will remain in effect during and after implementation of CHC. The Department will continue to set quarterly per diem rates for each nonpublic nursing facility provider under 55 Pa. Code Chapter 1187, Subchapter G (relating to rate setting) and 62 P.S. § 443.1(7)(iv) (relating to the budget adjustment factor) and annual per diem rates for each county nursing facility provider under Chapter 1189, Subchapter D (relating to rate setting).

   The rates established will be used to pay FFS claims during the phase-in of CHC. In addition, these rates will be used to pay a limited number of FFS claims expected after implementation of CHC for residents not enrolled in HealthChoices or waiting to be enrolled in CHC.

   **Note:** The MA portion of the Health Care-associated Infection surcharge and legislative additions such as the nonpublic Medical Assistance Day One Incentive payment will remain under FFS. The payments funded through Appendix 4 of the agreement between the department and each CHC-MCO (relating to nursing facility access to care payments) are in addition to the rate floor. (See Question No. 14) Additionally, the CHC-MCOs must provide a separate payment for exceptional durable medical equipment in addition to the rate floor. (See Question No 4)

   **Rate Floor:** For the first 36 months following the implementation date of each CHC phase, the CHC-MCO will be required to contract with nursing facilities at a facility specific per diem rate no lower than the rate floor, except as noted below.
The rate floor will not limit the CHC-MCOs or nursing facilities from agreeing to higher rates if necessary based on acuity, provider supply, or alternative payment methodologies. Any alternative payment methodology that would result in an initial rate that is lower than the established rate floor must be agreed to in writing by BOTH the nursing facility and the CHC-MCO.

For each CHC phase, the rate floor shall be established at the facility level as the average of each nursing facility’s per diem rate in effect for the four quarters prior to implementation. The quarterly rates and associated CMI picture dates and timeframe for each CHC Phase are indicated in the table below:

<table>
<thead>
<tr>
<th>Phase 1: January 2018</th>
<th>Southwest Counties: Allegheny; Armstrong; Beaver; Bedford; Blair; Butler; Cambria; Fayette; Greene; Indiana; Lawrence; Somerset; Washington; Westmoreland</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimum CHC Rate = average of prior 4 quarter case-mix rates</td>
<td>January 2017</td>
</tr>
<tr>
<td>Picture Date CMI</td>
<td>August 1, 2016</td>
</tr>
<tr>
<td>36-month period:</td>
<td>January 1, 2018 thru December 31, 2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Phase 2: July 2018</th>
<th>Southeast Counties: Bucks; Chester; Delaware; Montgomery; Philadelphia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimum CHC Rate = average of prior 4 quarter case-mix rates</td>
<td>January 2018</td>
</tr>
<tr>
<td>Picture Date CMI</td>
<td>August 1, 2017</td>
</tr>
<tr>
<td>36-month period:</td>
<td>January 1, 2019 thru December 31, 2021</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Phase 3: January 2019</th>
<th>Lehigh/Capital, Northwest &amp; Northeast Counties: Adams; Berks; Bradford; Cameron; Carbon; Centre; Clarion; Clearfield; Clinton; Columbia; Dauphin; Elk; Erie; Forest; Franklin; Fulton; Huntingdon; Jefferson; Juniata; Lackawanna; Lancaster; Lycoming; McLean; Mercer; Mifflin; Monroe; Montour; Northampton; Northumberland; Perry; Pike; Potter; Schuylkill; Snyder; Sullivan; Susquehanna; Tioga; Union; Venango; Warren; Wayne; Wyoming; York</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimum CHC Rate = average of prior 4 quarter case-mix rates</td>
<td>January 2019</td>
</tr>
<tr>
<td>Picture Date CMI</td>
<td>August 1, 2018</td>
</tr>
<tr>
<td>36-month period:</td>
<td>January 1, 2020 thru December 31, 2022</td>
</tr>
</tbody>
</table>
Change of Ownership. For nonpublic nursing facilities, a change in ownership (CHOW) will not impact the rate quarters used to determine the floor. For county nursing facilities, a CHOW may impact the rate quarters used to determine the floor. If a county nursing facility has a change of ownership from county ownership to a nonpublic nursing facility provider and one or more nonpublic rates are in effect at the time of implementation, the nonpublic rate will be used to determine the floor.

The rate floor established using this methodology will not be adjusted over the 36-month timeframe. However, the Department has agreed to take into account FFS rate increases and assumed increases to nursing facility costs caused by subsequent mandates on staffing, wages or related cost drivers enacted following implementation when calculating CHC’s capitated rates. These increases can then be negotiated between the CHC-MCOs and the nursing facilities.

2. Question: What services will be considered part of the per diem paid by the CHC-MCO?

Answer: Nursing Facility Services include at least the items and services specified in 42 CFR 438.1(c)(8)(i). Nursing facility services are covered as defined in 55 Pa Code Chapter 1187, Section 1187.51 (relating to scope). (Final Agreement pages 190)

3. Question: How will transportation services be provided and paid for under CHC, for NF residents?

Answer: Final Agreement pages 39-40 States: “The CHC-MCO must provide non-emergency medical transportation for NF residents. The CHC-MCO must also provide any specialized non-emergency medical transportation for Participants, including transportation for Participants who are stretcher-bound.

The CHC-MCO must provide all Participants with Medically Necessary emergency ambulance transportation and Medically Necessary nonemergency ambulance transportation. The CHC-MCO must provide all NFCE Participants with non-medical transportation. The CHC-MCO may provide non-medical transportation to other Participants at its own discretion and own cost. Non-medical transportation includes transportation to community activities, grocery shopping, religious services, Adult Daily Living centers, employment and volunteering, and other activities or LTSS services as specified in the Participant’s PCSP.

The CHC-MCO must provide non-emergency medical transportation for NF residents. The CHC-MCO must also provide any specialized non-emergency medical transportation for Participants, including transportation for Participants who are stretcher-bound.”

It was noted at the June Provider Summits that CHC-MCOs, through their service coordinators, are responsible for coordinating transportation for their Participants. DHS also
indicated that nursing facilities should discuss with each of the CHC-MCOs the process for paying and arranging for transportation. NFs can use the broker model but are not required to if they prefer to arrange for transportation as they have historically done. Agreement on the process and payment is between the NF and each CHC-MCO.

*Note: When contracting with the CHC-MCO plans nursing facilities should ensure that payment and the process for arranging for transportation services is specifically addressed.*

4. **Question**: How will bed hold days and therapeutic leave days be paid under CHCs – will the rates be as they currently are – 1/3 for bed hold and full per diem for therapeutic leave?

**Answer**: The CHC-MCO is responsible for payment for Medically Necessary NF services, including bed hold days up to fifteen (15) days per hospitalization and up to thirty (30) Therapeutic Leave Days per year if a Participant is admitted to a NF or resides in a NF at the time of Enrollment. (Final Agreement pages 41-42)

To qualify for bed hold payments nursing facilities will be required to meet or exceed the current overall occupancy threshold of 85%. The Department will continue to use the formula contained in 55 Pa Code Chapter 1187 § 1187.104 (relating to limitations on payment for reserved beds) to calculate each nursing facility’s overall occupancy rate.

The Department has indicated that the payment per diem for bed hold days is to be negotiated with the CHC-MCO. When contracting with the CHC-MCO plans nursing facilities should address the payment of bed hold days as well as therapeutic leave days with the plans.

*Nursing facilities should ensure that these payment provisions are addressed in the network contract with each CHC-MCO.*

5. **Question**: How will a nursing facility resident’s need for exceptional DME be considered in rate setting process under CHC?

**Answer**: The CHC-MCO must operate a grant process to provide grants for Exceptional DME and Ventilators. The amount of the additional payment authorized by a grant is based upon the necessary, reasonable and prudent cost of the Exceptional DME/Ventilators and the related services and items specified in the grant. The Department will publish the Exceptional DME List and annual notice in the *PA Bulletin*. The Department will publish the Ventilator Supply List and annual notice in the *PA Bulletin*. (Final Agreement page 45)

An Exceptional DME/Ventilator grant is an authorization permitting exceptional payments under specified terms to a NF, in addition to the NF’s case-mix per diem rate, for NF services that are provided to a specified resident and that involve the use of certain exceptional DME and ventilator supplies.
For Southeast NFs any wheelchairs or augmentative communication devices approved prior to January 1, 2019, DHS will be responsible for follow-up and payment. Any bed or mattress rentals that were approved prior to January 1, 2019 but continue in the new year will be transferred to the CHC-MCO for follow-up and payment. Any request received prior to January 1, 2019 but have not been reviewed by DHS will be transitioned to the CHC-MCO for review and payment.

The Department will be amending their agreement with the CHC-MCOs to allow the DME vendor that is providing the exceptional DME to bill the CHC-MCO directly. There will be a medical necessity determination and review conducted by the respective plan, nursing facilities should ask the plans for the procedures and policies related to this process. It is recommended that nursing facilities work to ensure that the DME vendors they have historically used to provide exceptional DME to their residents becomes a provider in the CHC-MCO plans network.

Ventilator Dependent Resident Program – part of the exceptional DME program. Payments related to ventilator supplies will continue to be paid directly to the nursing facilities for residents that qualify for these payments. It is recommended that nursing facilities that provide services to ventilator dependent residents ask each of the CHC-MCOs for the policies and procedures for these payments.

6. **Question**: How will the following payments be made under Community HealthChoices?
   a. Disproportionate Share Payments
   b. Ventilator/Tracheostomy Supplemental Payments
   c. Hospice Payments
   d. Healthcare-Associated Infection Surcharge Payments
   e. Nonpublic MDOI Payments

**Answer**: The table below outlines the current information regarding the noted payments.

<table>
<thead>
<tr>
<th>Payment</th>
<th>Under FFS</th>
<th>Under CHC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disproportionate Share</td>
<td>DHS pays qualifying NFs on an annual basis.</td>
<td>These payments are included in the determination of the actuarially sound rates to be paid to CHC-MCOs. <em>NFs must negotiate these payments with each MCO. Moving to CHC the payments will be individual based not facility based as they currently are under the FFS</em></td>
</tr>
<tr>
<td>Payments Type</td>
<td>Description</td>
<td>Notes</td>
</tr>
<tr>
<td>---------------------------------------------------</td>
<td>-----------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------</td>
</tr>
<tr>
<td>Ventilator/Tracheostomy Supplemental Payments</td>
<td>DHS pays qualifying NFs a supplemental Vent/Trach payment on a quarterly basis.</td>
<td>These payments are included in the determination of the actuarially sound rates to be paid to CHC-MCOs. <strong>NFs must negotiate these payments with each MCO. Moving to CHC the payments will be individual based not facility based as they currently are under the FFS program.</strong></td>
</tr>
<tr>
<td>Hospice Payments</td>
<td>NFs bill DHS directly and receive payment through the PROMISe system.</td>
<td>The hospice provider will bill the CHC-MCO for any hospice services rendered and the NF will bill the CHC-MCO plan for room and board. The NF will be responsible for the collection of the patient pay from the resident.</td>
</tr>
<tr>
<td>Healthcare-Associated Infection Surcharge Payments</td>
<td>DHS pays each NF their MA portion of the HAI surcharge on an annual basis.</td>
<td>DHS pays each NF their MA portion of the HAI surcharge on an annual basis.</td>
</tr>
<tr>
<td>Nonpublic MDOI Payments</td>
<td>DHS pays qualifying NFs a quarterly nonpublic MDOI payment based on an established schedule.</td>
<td>DHS pays qualifying NFs a quarterly nonpublic MDOI payment based on an established schedule.</td>
</tr>
</tbody>
</table>

7. **Question:** If a resident is dual eligible and on regular Medicare – how is the coinsurance paid to the nursing facility?

**Answer:** “The CHC-MCO must pay Medicare deductibles and coinsurance amounts relating to any Medicare-covered service for Dual Eligible Participants not to exceed the contracted CHC-MCO rate. The CHC-MCO will not be responsible for copayments or cost-sharing for Medicare Part D prescriptions. If no contracted CHC-MCO rate exists or if the Provider of the service is an Out-of-Network Provider, the CHC-MCO must pay deductibles and coinsurance up to the applicable MA fee schedule rate for the service.” (Final Agreement page 122)
8. **Question:** What is CHC’s impact on Third Party Liability (TPL)?

**Answer:** Under CHC the MA program will continue to be the payer of last resort. All forms of third party medical coverage must be exhausted before CHC-MCOs will pay for a covered item or service. Providers will bill the participant’s CHC-MCO for services provided. If the participant has TPL coverage, including Medicare, providers must bill the TPL first for payment of eligible services and obtain an EOB from the primary insurer. Once the TPL has paid or denied the claim, providers may bill the CHC-MCO for the remainder of the claim.

9. **Question:** Will retroactive eligibility for NF services continue under CHC?

**Answer:** Yes, a NF resident may be eligible for retroactive MA to cover the cost of NF services. The retroactive period begins as early as the first day of the third calendar month before the application date and ends the day before the application date.

10. **Question:** What entity pays the nursing facility for the services provided to the resident for the retroactive period of MA coverage after the resident is deemed MA eligible (MA pending period)?

**Answer:** “The CHC-MCO shall not be responsible for any payments owed to Providers for services that were rendered prior to the effective date of a Participant’s Enrollment into the CHC-MCO.” (Final Agreement page 119)

DHS has confirmed that payment for MA pending days will be covered by DHS under FFS. The rate that a nursing facility will be paid for the pending period is the case-mix per diem rate calculated in accordance with the rate setting provisions contained in 55 PaCode Chapter 1187.

If the resident is admitted under the current HealthChoices program and remains in the NF passed the 30-day covered period, the Department has indicated that the HealthChoices MCO will be responsible for any MA pending period between the 31st day and the day the resident is determined to be MA eligible for nursing facility services and has chosen a CHC-MCO plan. The HealthChoices MCO will hold payment until the determination of MA eligibility is made by the Department and reimburse the nursing facility retroactively. For more information review the Admission Payor 30-Day Benefit Chart at [https://www.phca.org/wp-content/uploads/2018/07/Admission-Payor-Chart-30-Day-Benefit.pdf](https://www.phca.org/wp-content/uploads/2018/07/Admission-Payor-Chart-30-Day-Benefit.pdf).

*Note: Nursing facilities should consider what amendments will be necessary to their HealthChoices MCO contracts to accommodate this change in practice.*

11. **Question:** What entity is responsible for collecting a resident’s Patient Pay/Liability? What entity will be responsible for auditing the patient pay deductions made by the nursing
facility? How are the deductions permitted against a resident’s patient pay under MA FFS addressed under CHC?

**Answer:** Based on discussions with DHS, nursing facilities will be responsible for collecting the cost-of-care liability. MCOs will be responsible for the management of the patient pay process and auditing of those deductions. DHS indicated that research will be conducted with other states to determine best practice.

Deductions will remain the same between FFS and managed care.

Issues raised with DHS regarding the allowable deductions: if the MCO is responsible for managing the patient pay and the allowable deductions it will be imperative that the Department develop a list of allowable deductions to ensure consistency across all MCOs and avoid issues regarding these deductions. The Department has indicated that they will not be developing a list of allowable deductions, the deductions currently permitted will continue to be permitted under CHCs.

Note: Nursing facilities should consider addressing allowable deductions when meeting with CHC-MCO plans, to determine if they are including any value-add services in their plan coverage that have routinely been services deducted from a resident’s patient pay.

**Verifying Patient Pay Amounts.** Nursing facilities will continue to receive PA 162s from the CAOs which include the amount of the resident’s patient pay liability. The CHC-MCOs will not receive the PA 162 but will receive an electronic report from the Department that will provide the resident’s MA recipient information, including the patient pay liability amount. As a result, to ensure that the patient pay amount received by the CHC-MCO and the patient pay amount received by the nursing facility on the PA 162 are consistent, it will be necessary for nursing facilities to verify the patient pay amount in EVS. Nursing facilities should work with the CHC-MCO and CAO to resolve any differences in patient pay. If the CHC-MCO has a question or finds a billing mismatch, the CHC-MCO should contact the nursing facility.

**12. Question:** Timeliness of payments and cash flow concerns. How will DHS ensure that claims for services are paid timely? What process will DHS put in place to address untimely payments and cash flow issues for network providers – specifically nursing facility providers? Will system testing be required?

**Answer:** Claims received from any Provider: 90% of Clean Claims within 30 days of receipt; 100% of Clean Claims within 45 days of receipt and 100% of all Claims within 90 days of receipt. (Final Agreement page 115-116)
If the Department determines that a CHC-MCO has not complied with the Claims Processing timeliness standards, the Department may separately impose the following sanctions to the following claims types: Inpatient Claims. NF. Claims other than Inpatient, NF, and drug.

The CHC-MCO will be considered in compliance with the requirement for adjudication of 100% of all Inpatient and NF Claims if 99.5% of all Inpatient and NF Claims are adjudicated within ninety (90) days of receipt. The CHC-MCO will be considered in compliance with the requirement of adjudication of 100% of all Claims other than Inpatient, NF and drug if 99.5% of all Claims other than Inpatient, NF and drug are adjudicated within ninety (90) days of receipt.

Note: For SouthEast – CHC Phase II nursing facilities claims testing is currently available with all of the CHC-MCO plans. The Department indicated during the June Provider Summits that a nursing facility is not required to be contracted with a plan to conduct claims testing. Claims testing will include, among others, testing of various claim types identified through meetings with nursing facility representatives and NF association representatives prior to the implementation of Phase I. Information on the types of claims to be tested can be found in the documents linked to below.


Nursing facilities in Phase II are encouraged to take advantage of claims testing to ensure minimal interruption in cash flow when CHC is implemented.

13. **Question:** Provider Claim Submission. What are the requirements regarding submission of claims to the CHC-MCO?

**Answer:** The CHC-MCO must require Providers to submit claims to the CHC-MCO within one hundred eighty (180) days after the date of service. The CHC-MCO may require more prompt submissions of Claims or Encounter records in Provider Agreements and Subcontracts. Claims adjudicated by a third-party vendor must be provided to the CHC-MCO by the end of the month following the month of adjudication. (Final Agreement page 130)

The CHC-MCOs are required to train providers on claim submission. Per the CHC agreement, each CHC-MCO must have a Provider Claims Educator who is located in Pennsylvania and facilitates the exchange of information between grievances, claims processing and provider relations systems. This includes educating contracted and non-contracted providers on appropriate claims submission requirements, coding updates, electronic claims transaction...
and electronic fund transfer, and available CHC-MCO resources such as provider manuals, websites, fee schedules, etc.

14. **Question:** Will the 180-Day exception rule still exist for retroactive billing during the transition from Fee-for-Service to CHC?

**Answer:** Yes, to receive FFS payment for nursing facility services provided during the retroactive eligibility period, the nursing facility must comply with the 180-day exception rule in 55 Pa.Code §1101.68(c) and (d).

15. **Question:** How is the provider assessment program implemented during the phase-in of CHC? How is the provider assessment program implemented after full CHC statewide? How are providers able to identify these assessment payments broken out separately from their other Medicaid reimbursement? Will the State continue to set the payout amounts?


The current concept/process, is described below.

**Nursing Facilities under CHC:**

- **Assessment Fees:** The Department will continue to establish the assessment fees to be paid by nursing facilities under the NF provider assessment program. Nursing facilities located in a CHC Zone will continue to pay the Department the established assessment fees, by the due dates designated by the Department.

- **Resident days:** Similar to the FFS NFs the assessment fee payments will be based on resident days from a prior year – for 17/18 the days were the 2015 CY days; for 18/19 the days will be the 2016 CY days. Although the assessment program will be based on previously submitted days, nursing facilities will continue to be required to submit current resident days in accordance with the Department’s “Important Dates” schedule. The reporting of days will change for nursing facilities in a CHC zone. Nursing facilities will be asked to report the days based on the CHC-MCO plan that the resident is enrolled in.

- **Payments:** As a result of the final federal Managed Care rules, nursing facilities located in a CHC Zone will no longer receive the supplemental payments and allowable cost payments directly from the Department. Payments resulting from the assessment program will be paid directly to the nursing facility from the CHC-MCOs.

The CHC-MCOs will receive the assessment funds from the Department as a component of the PM/PM payment made monthly to the plans. According to Appendix 4 provisions CHC-MCOs will be required to pay a NF Access to Care payment to each nursing facility within 30-days of receiving payment from the Department. The PM/PM is paid monthly by the Department to the
CHC-MCO therefore the CHC-MCO will be required to make the Appendix 4 payments to nursing facilities on a monthly basis.

At the request of the NF Trade Associations, the Department prepares a monthly report that identifies the amount of Appendix 4 funds distributed to each CHC-MCO for the month. This report is provided to the Associations. The Associations contracted with an entity to determine the payments that each nursing facility is to receive for that month based on an agreed upon methodology. Each CHC-MCO is provided a list of the payments they are to make to each nursing facility.

*Implementation of change by CHC Phase:* Nursing facilities in Southwest CHC Phase 1 experienced this change beginning January 1, 2018– 6 months into FY 17/18. Nursing facilities in Southeast CHC Phase 2 will see this change beginning January 1, 2019 – 6 months into FY 18/19. Nursing facilities in CHC Phase 3 will see this change beginning January 1, 2020 – 6 months into FY 19/20.

*Note:* The Appendix 4 payments will be made by each of the CHC-MCOs outside of the claims processing system. Therefore, nursing facilities should ensure that each of the CHC-MCO plans have the banking information needed to transfer the payments to the nursing facility.

**CHC Enrollment/Eligibility Q & As**

16. **Question:** Continuity of Care. How will continuity of care be addressed in the phase-in of CHC?

**Answer:** Final Agreement Pages 48 – 49 states:

A Participant who resides in an NF located in the CHC zone on the Implementation Date must receive NF services from the same NF until the earliest date any of the following:
- a. The Participant’s stay in the NF ends.
- b. The Participant is disenrolled from CHC.
- c. The NF is no longer enrolled in the MA Program.

If a Participant appeals a decision to transfer or discharge the Participant from the NF, the continuity of care period will continue until the Participant’s appeal is adjudicated by BHA.

A change in CHC-MCO, a temporary hospitalization, or therapeutic leave does not interfere with or terminate this continuity of care period as long as the Participant remains a resident of the NF.

The CHC-MCO in which the Participant is enrolled must enter into an agreement or payment arrangement with the Participant’s NF to make payments for the Participant’s NF services during the continuity of care period, regardless of whether the NF is in the CHC-MCO Network.
To meet this requirement the Department expects CHC-MCOs to pay all NFs at the FFS level unless the parties otherwise agree to another payment arrangement.

The CHC-MCO may require Out-of-Network NFs to meet the same requirements as Network NFs, with the exception that a CHC-MCO may not require Out-of-Network Providers to undergo full credentialing.

Participants admitted to a nursing facility after the CHC implementation date will receive the standard 60-day continuity of care protections. Participants who are admitted to a NF after the Start Date for the CHC-MCO, or who do not qualify for the continuity of care period in this section, will receive the continuity of care described in MA Bulletin 99-03-13.


17. **Question:** Are there continuity-of-care requirements for nursing facility residents who have been admitted to a hospital or have a primary care physician that is not included in the CHC-MCO’s provider network?

**Answer:** Nursing facility residents who are dual eligible can keep their Medicare PCP for both CHC and Medicare. For all participants, the CHC-MCO must comply with continuity-of-care requirements for continuation of providers, services, and any ongoing course of treatment outlined in the MA Bulletin 99-03-13, Continuity of Care for Recipients Transferring Between and Among Fee-for-Service and Managed Care Organizations. (See MA Bulletin 99-03-13 under Question 13 above).

18. **Question:** How are the current Medicaid residents in nursing facilities transitioned into CHC? What support is provided to nursing facilities to assist them in making an informed decision on the CHC-MCO that can best meet their needs?

**Answer:** In meetings with DHS, DHS indicated that they will be initiating education for consumers and providers prior to implementation in each zone. They will seek the support of all stakeholders to assist with education.

The Department developed an online training module to educate NF staff so they can assist their residents as they transition to CHC. The training can be found at [http://www.healthchoices.pa.gov/providers/about/community/index.htm](http://www.healthchoices.pa.gov/providers/about/community/index.htm)
The presentations from the recent Provider Summits can be found at [http://www.healthchoices.pa.gov/providers/about/community/presentations/index.htm](http://www.healthchoices.pa.gov/providers/about/community/presentations/index.htm).


19. **Question**: How are residents that spend down in the nursing facility enrolled into CHC-MCO? How is the financial eligibility process completed as well as the clinical eligibility process?

**Answer**: PHCA participated in multiple meetings with DHS on the topic of enrollment and eligibility under CHC. As a result of these meetings, to assist nursing facilities, flow charts that outline the process and the responsible entity were developed. A webinar was also provided to review the flow charts. Links to the flow charts and webinar presentation are below.


*Financial Eligibility.* The CAOs will continue to be responsible for determining the financial eligibility for LTSS and nursing facility services. There will however be changes to the flow of the process. Under CHC an Independent Enrollment Broker (IEB) will be required to have a role in this process.

The IEB is responsible for facilitating the eligibility and enrollment process and providing choice counseling to assist consumers in selecting a CHC-MCO plan. Nursing facilities may continue to manage the financial eligibility process for their residents. Although paper applications will be accepted nursing facilities are encouraged to submit MA applications through COMPASS. If the nursing facility submits the MA application through COMPASS this will trigger the IEB to contact the nursing facility to schedule time to conduct choice counseling for the resident while the application is being processed. If the nursing facility choses to submit a paper application, the nursing facility must also submit a form to the IEB requesting choice counseling for the resident.

For a copy of the Nursing Facility Referral Form, that should be used to inform the IEB of the need for choice counseling, go to [https://www.phca.org/wp-content/uploads/2018/07/NursingFacilityReferralForm_WEB.pdf](https://www.phca.org/wp-content/uploads/2018/07/NursingFacilityReferralForm_WEB.pdf).
Clinical Eligibility. Under CHC Aging Well, LLC, (new entity composed of the AAAs) is responsible for determining clinical eligibility for nursing facility services. DHS has developed a new tool that will be used to make this determination. The tool is a subset of the InterRAI HomeCare and is being referred to as a Functional Eligibility Determination (FED) tool.

The FED is an electronic tool that establishes Nursing Facility Clinically Eligible (NFCE) based on scoring and algorithm. The assessors have been trained and the tool tested, it is anticipated that the FED will be implemented statewide on September 3, 2018. The MA-51, physician certification will continue to be required in the process.

The IEB is the entity to notify Aging Well, LLC, that a FED needs to be conducted. If the nursing facility submits an application through COMPASS the IEB will receive notification and will be prompted to notify Aging Well that a FED needs to be conducted. The details around this process are part of the flow charts provided above.

The full InterRAI HomeCare tool is the tool DHS is requiring that the CHC-MCOs use to conduct an assessment of the consumer to establish their care plan. Note: The InterRAI HomeCare tool will not be used for consumers residing in nursing facilities.

The Department agreed to allow the CHC-MCOs to utilize the MDS tool as the comprehensive clinical assessment for participants residing in nursing facilities. Nursing facilities will be required to work with the respective plans to develop a process for sharing the MDS information related to the residents participating in their respective plans.

20. Question: If the resident is approved for MA with a penalty period, does the HealthChoices MCO or CHC-MCO continue to provide service coordination and ensure all required services are provided during the penalty period?

Answer: A participant that is in a penalty period will remain in CHC or HC. If the individual requires service coordination, the participant’s MCO should assist in coordinating with other insurers such as Medicare and in identifying other entities that can provide service. However, the MCO is not responsible for covering NF services, or long-term services and supports under CHC during the penalty period because the individual is not eligible for payment of LTC facility services or home and community-based services during the penalty period.

21. Question: Will the annual re-determination still be done and by whom?

Answer: As required by Federal Law, annual redeterminations will still be conducted under CHC. The Department of Human Services’ independent assessment entity will conduct the annual redeterminations of clinical eligibility based upon documentation and information which the CHC-MCOs will gather when conducting their comprehensive needs assessments. The county assistance office will conduct annual redeterminations of financial eligibility.
22. **Question:** Will prior medical expenses still be considered after CHC implementation?

**Answer:** Medical Assistance eligibility requirements and rules governing allowable expenses will not change under CHC. The Office of Income Maintenance Long-Term Care manual section 468.3 provides additional information on allowable medical expenses. [http://services.dpw.state.pa.us/oimpolicymanuals/ltc/long-term_care_handbook.htm](http://services.dpw.state.pa.us/oimpolicymanuals/ltc/long-term_care_handbook.htm)

23. **Question:** Will threshold guidelines change for new MA applicants, the look back period or retroactive eligibility?

**Answer:** MA eligibility requirements will not change under CHC.

24. **Question:** Who can assist the resident with plan selection?

**Answer:** One of the roles of the Independent Enrollment Broker (IEB) is to provide plan counseling to nursing facility residents in a CHC zone. When an MA application is submitted for a resident of a nursing facility, the IEB is notified either through COMPASS or the IEB Referral Form. Within 5 business days of that notification, the IEB is to contact the nursing facility to schedule and conduct phone consultation with the resident, their POA- whoever is appropriate – regarding the selection of a CHC plan. (See the links to the Flow Charts above under Question 15) The NF referral form can be found at the link under Question 15 above or on IEB webpage at [https://www.paieb.com/](https://www.paieb.com/). Additional information related to the IEB and enrollment into CHC can be found at [https://www.enrollchc.com/](https://www.enrollchc.com/).

25. **Question:** What is the timing for plan selection and auto assignment into a plan?

**Answer:** Plan Selection/Notices for SouthEast consumers.

The Department intends to distribute pre-transition notices and CHC enrollment information to all SouthEast participants in August 2018. Between August and October 2018 Aging Well will provide educational sessions to participants. Between September and November participants will conduct plan selection. According to the information shared at the June Provider Summits consumers will have until November 14th to select a CHC-MCO plan. If a plan is not selected by that date the consumer will be auto assigned to a plan. The consumer will have until mid- December (around December 18th – 20th) to change the plan selected or assigned to be effective January 1, 2019.

The criteria for auto assignment for consumers that are NFCE are noted below:

- First, if on the Enrollment Date the individual is residing in a NF that is a network provider in only one CHC-MCO, the individual will be enrolled in that CHC-MCO.
- Second, if the individual is enrolled in a D-SNP, the individual will be enrolled in the CHC-MCO that is aligned with that D-SNP.
• Third, if the individual is transferring from HealthChoices and is a member of a Physical Health HealthChoices MCO that is a CHC-MCO, the individual will be enrolled in that CHC-MCO.
• Last, if the individual’s PCP is a network provider with only one CHC-MCO, the individual will be enrolled in that CHC-MCO.

Note: this information can be found in Exhibit J of the Agreement.

The Department has also established dating rules for participants that choose to change plans. The participant is permitted to change their plan selection at any time, the dating rules will determine when the change is effective. In general, if the participant chooses to change plans at some time from the 1st to the 15th of the month the effective date will be the first day of the following month. If the participant chooses to change plans at some time from the 16th to the end of the month the effective date will be the first day of the second month after the selection was made.

For example, the participant chooses to change plans on January 10th – the effective date would be February 1st; if the participant chooses to change plans on January 20th the effective date would be March 1st.

26. Question: If a person is eligible to receive services through the Office of Developmental Programs (ODP), but they don’t receive any ODP services, are they required to enroll in CHC?

Answer: Individuals with an intellectual or developmental disability, who are eligible to receive, or are receiving services through a program administered by ODP, will not be enrolled in CHC unless they are nursing facility clinically eligible and choose to enroll in CHC.

27. Question: How will nursing facilities know which CHC-MCO their residents have selected?

Answer: The current Eligibility Verification System (EVS) will identify CHC participants and their CHC-MCO. EVS will display the CHC-MCO plan code information along with the participants Primary Care Physician (PCP).

28. Question: What happens if a long-term services and supports participant who resides in a nursing facility is originally from a county that is not in the same phase of CHC implementation as the nursing facility?

Answer: The LTSS participant’s enrollment in CHC will be determined based upon the location of the nursing facility.
Independent Enrollment Broker

**29. Question:** Does the IEB come into the nursing facilities?

**Answer:** Yes, IEB representatives may come into a nursing facility. Once CHC is implemented in a zone, the IEB will assist individuals who are applying to receive nursing facility services through CHC with the LTSS eligibility process and in selecting or changing his/her CHC-MCO plan or, if eligible, to educate on the LIFE program. In providing enrollment assistance to these individuals, the IEB will coordinate and cooperate with the residents’ nursing facility. At a minimum, the IEB will work with the nursing facility in scheduling visits with and facilitating functional and financial eligibility determinations for nursing facility residents. If a LTSS applicant designates a nursing facility as a contact, the IEB will also provide the nursing facility with informant relating to the status of the individual’s LTSS application.

**30. Question:** How will the IEB communicate with nursing facility staff or with the CHC-MCO or both?

**Answer:** The IEB will communicate with both nursing facility staff and CHC-MCO staff when performing enrollment activities for nursing facility residents. The IEB may contact nursing facilities and CHC-MCOs by telephone, in writing, or in person.

**31. Question:** What is the role of the IEB for a Medical Assistance (MA) individual residing in a nursing facility?

**Answer:** The IEB will assist nursing facility residents and nursing facility staff in managing the enrollment process. This includes selecting a CHC-MCO, making referrals to a local LIFE provider, processing requests to change CHC-MCO plans, providing enrollment materials, assisting CHC participants and long-term services and supports applicants through the MA clinical and financial eligibility process, and providing information on nursing home transition.

**32. Question:** Does the facility or IEB complete the MA application process?

**Answer:** Nursing facilities can originate the enrollment application process through COMPASS if they are a community partner. Nursing facilities may also contact the IEB to begin the application process. Nursing facilities may also complete a paper application and submit it to the CAO. Applications not originated by the IEB will be transmitted to the IEB to send out enrollment materials and assist the CHC participant with CHC-MCO plan selection.

*Additional information on the IEB can be found in responses to Questions 18 above.*
Behavioral Health Services

33. **Question:** What will be done to address the needs of individuals residing in nursing facilities with long-term needs with symptoms of behavioral health disorders?

**Answer:** CHC-MCOs will be required to coordinate care with Pennsylvania’s behavioral health MCOs to ensure that the needs of participants with behavioral health issues are addressed, regardless of where they reside.

34. **Question:** How will the CHC-MCO coordinate the need for services with the Behavioral Health plan?

**Answer:** Final Agreement Pages 75-76 states that each CHC-MCO is required to have a BH Coordinator who is a behavioral health professional and is located in Pennsylvania. The Behavioral Health Coordinator shall monitor the CHC-MCO for adherence to BH requirements in the Agreement. The primary functions of the BH Coordinator are:
- Coordinate Participant care needs with BH Providers.
- Develop processes to coordinate behavioral healthcare between PCPs and BH Providers.
- Participate in the identification of best practices for BH in a primary care setting.
- Coordinate behavioral care with medically necessary services.
- Be knowledgeable of the BH Managed Care Agreement requirements and coordinate with the BH-MCO to effectuate the requirements.

If a NF identifies a resident with a behavioral health need the NF should inform the resident’s service coordinator so the service coordinator can begin the process of coordinating the services needed by the resident.

35. **Question:** Are behavioral health services part of the nursing facility rates or will behavioral health providers be reimbursed by the CHC-MCOs directly for behavioral health services provided to the nursing facility resident?

**Answer:** Under CHC, BH services are not part of the nursing facility rates. BH providers will be reimbursed by the BH-MCOs for medically necessary BH services provided to nursing facility residents, as authorized by the BH-MCO. Currently, there are five BH-MCOs that provide managed care to MA eligibles across the Commonwealth.
- Community Behavioral Health
- Community Care Behavioral Health
- Magellan Behavioral Health
- PerformCare
- Beacon Health Options (formally Value Behavioral Health)
The counties which each of the BH-MCOs cover can be found in the presentation linked to under Question 36 below.
36. **Question:** Can more specifics be provided on what behavioral health services nursing facilities might have available to residents?

**Answer:** If an individual in a nursing facility is determined to be in need of specialized behavioral health services, as determined by the pre-admission screening and resident review (PASRR) program, then those services will be managed by the BH-MCO. The mental health services provided through the BH-MCO will be specified in an individualized plan of care that is developed for the individual and supervised by an interdisciplinary team. These services will be provided at a higher intensity and frequency than the mental health services which are typically provided by the nursing facility. Some examples include partial hospitalization, psychiatric outpatient clinic, mental health crisis intervention, mobile mental health treatment, peer support services, and mental health targeted case management. *The Department along with the BH-MCOs provided a webinar on behavioral health services under CHC. The presentation from the webinar is available at [https://www.phca.org/wp-content/uploads/2018/07/BH-101-NF.pdf](https://www.phca.org/wp-content/uploads/2018/07/BH-101-NF.pdf).*

**Nursing Home Transition:**

37. **Question:** Will nursing facilities continue to counsel and refer directly to Nursing Home Transition (NHT) providers or will the process move to the CHC-MCOs?

**Answer:** Nursing facilities will counsel their residents and make referrals for NHT services to the CHC-MCO and service coordinator chosen by the resident.

38. **Question:** What impact does the Department of Human Services expect CHC to have on nursing home transition (NHT)? And what steps are being taken to support NHT?

**Answer:** One of the goals of CHC is to enhance opportunities for community-based living. To support this goal, DHS is requiring CHC-MCOs to provide nursing home transition activities to participants residing in nursing homes who express a desire to move back to their homes or other community-based settings. DHS anticipates that with more support from CHC-MCOs, more individuals will be served in the community.

DHS recognize that housing is a major barrier in NHT and has developed a housing plan to help address housing barriers. The Department has also established targeted housing as one of the service delivery innovations that CHC-MCOs must support.

**Quality and Oversight**

39. **Question:** Will nursing facility records still be reviewed as part of the OLTL utilization management teams review process?
Answer: OLTL’s utilization management review teams will continue to monitor minimum data sets and preadmission screening and resident reviews. These teams will also monitor MA billing until CHC starts in a zone.

40. Question: Will the UMR and QMET continue to review and audit a provider’s billing and claims?

Answer: The functions done by the UMR and QMET teams today will be the role of the CHC-MCOs in CHC. The CHC-MCOs will be responsible for reviewing and auditing provider’s billing and claims. As part of its required compliance, the CHC-MCOs will establish policies and procedures for review of provider claims. The DHS through its oversight responsibility will monitor utilization and quality through reports and financial information submitted by the CHC-MCOs.

41. Question: Will CHC-MCOs be responsible for the NF care plans, and what happens to the care plan during the DOH survey?

Answer: Nursing facilities are responsible to develop care plans and provide services consistent with state licensing requirements and federal conditions of participation. The DOH will continue to enforce state licensing requirements and act as the State Survey Agency for federal survey and certification purposes. The CHC-MCO will review participant’s nursing facility care plan and use this information in developing the person-centered service plan (PCSP). The CHC-MCOs will determine the roles of the nursing facility in the PCSP process. Nursing facilities should discuss roles in PCSP development with the CHC-MCOs.

42. Question: Will the CHC-MCO and the Independent Enrollment Broker meet Department of Health requirements related to background checks prior to having access to nursing facility residents?

Answer: The CHC-MCO and IEB must, at their own expense, arrange for criminal background check for each of its employees, as well as the employees of any of its subcontractors, who will have access to Commonwealth data and information technology facilities, either through on-site access or through remote access. Background checks must be conducted via the Request for Criminal Record Check form and procedure found at [http://epatch.state.pa.us](http://epatch.state.pa.us). If an employee has not been a resident of Pennsylvania for the last two years, an FBI clearance check from the state of residence during the last two years, is required. The background check must be conducted prior to initial access, prior to the provision of intake and enrollment services by the individual, and thereafter on an annual basis.

The CHC-MCO and IEB must arrange, at their own expense, for a child abuse clearance for all personnel who will have contact with children at the time of hiring.
Miscellaneous Q & As:

43. Question: What are the Provider Credentialing requirements?

Answer: Final Agreement Credentialing is addressed on pages 30, 89, 98, Exhibit F pages 247-268.

44. Question: How will the CHC-MCO offer the resident a choice of Service Coordinators and how will this be communicated to the nursing facility?

Answer: The CHC-MCO plans indicated that Service Coordinators for nursing facility residents will be direct employees of the CHC-MCO plan. The Service Coordinators will generally be social workers and nurses. In general, service coordinators will be assigned to a nursing facility (the number assigned will depend on the number of participants in the NF). If the resident is unhappy with their service coordinator the resident will be offered the choice of another service coordinator.

45. Question: How will the CHC-MCO Service Coordinator coordinate the clinical assessment and care plan for the resident with the nursing facility staff?

Answer: The CHC-MCO must conduct needs assessments according to the agreement with the Department. The CHC-MCO will use the MDS instead of the InterRAI Home Care assessment to develop a participants person-centered service plan (PCSP) that is residing in a NF. The NF will continue to conduct assessments of resident’s needs, strengths, goals, life history and preferences using the MDS. The CHC-MCO and the NF need to coordinate a participant’s PCSP and comprehensive person-centered care plan.

Nursing facilities will be required to work with the respective plans to develop a process for sharing the MDS information related to the residents participating in their respective plans.

46. Question: How will the CHC-MCO Service Coordinator support the nursing facility with discharge planning and ensuring a safe and orderly discharge that meets the requirements of the federal rule?

Answer: When meeting with the CHC-MCO plans it is recommended that nursing facilities gain an understanding from the MCO how the Service Coordinator will work in the building with the residents and staff. Nursing facilities should understand the role of the service coordinator and based on that develop procedures that can be integrated into the daily operations of the nursing facility. Nursing facilities are encouraged to look at service coordinators as another resource to support the care needs of the resident.
47. Question: How will CHC-MCOs work with nursing facilities to ensure the ancillary providers that have relationships with the facility are part of the MCOs network?

Answer: The nursing facility should work to ensure that any ancillary providers that provide services to your MA residents – that bill MA directly – are enrolled in the CHC-MCOs networks. Any ancillary provider that the nursing facility has a contract with and the nursing facility pays the ancillary provider directly for the services IS NOT required to be enrolled in the CHC-MCOs network.

Primary Care Physician (PCP): An MA resident’s PCP MUST be enrolled in the MA program and have an MA provider number and MUST be enrolled in the CHC-MCOs network. If the PCP is only enrolled under Medicare and wants to limit his/her practice to their current MA recipients – the physician MUST enroll as an MA provider – however this will not require the PCP to open up his/her practice to additional MA recipients. The PCP MUST also enroll in the CHC-MCOs network as a “suppressed” provider. In this situation, the PCP will NOT be listed in the CHC-MCOs network and NOT counted in their network adequacy numbers. 

NOTE: In recent discussions with the Department, the Department indicated that this may change they have been in communication with CMS on this issue.

48. Question: How will the CHC-MCO communicate with the nursing facility staff regarding:
   a. Changes to a resident’s care plan,
   b. Changes to billing processes
   c. Changes to reporting processes etc.

Answer: It is recommended that nursing facilities ask these questions when contracting with the CHC-MCO plans.

49. Question: How will critical incident reports be managed by the CHC-MCOs?

Answer: The CHC-MCO must comply and require their home and community-based services and nursing facility network providers to comply, with the Department’s critical incident reporting and management, provider-preventable, condition, and provider serious adverse events reporting requirements.

CHC-MCOs must also ensure that network providers comply with the reporting requirements established in the Older Adult Protective Services Act and the Adult Protective Services Act.

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

50. Question: Once CHC is implemented, will incident reporting change for nursing facilities?
Answer: Nursing facilities should report critical incidents, including preventable serious adverse events, to CHC-MCOs. Nursing facilities will continue to submit reportable events to the Department of Health through DOH’s system. The CHC-MCOs should determine which reportable events nursing facilities should also report to the CHC-MCO.

51. Question: What reporting will the nursing facility be required to provide to the CHC-MCO? What are the requirements around incident reporting?

Answer: It is recommended that nursing facilities ask these questions when contracting with the CHC-MCO plans. See Critical Incident Reporting and Management in Exhibit W(1) on pages 370-371 of the Community Health Choices Agreement in the Resources Section below.

Resources


Some of the other provisions that may be of specific interest to our members can be found on the pages listed below:

- Transportation and Hospice Services: Pages 39 – 40 and 188-189
- Nursing Facility Services – Pages 41-42 and 189
- Settings for LTSS – Page 43
- Workforce Innovation – Page 44
- Exceptional DME – Page 45 and 180-181
- Prior Authorization- Pages 45-46
- Continuity of Care – Pages 48-49
- Comprehensive Needs Assessment – Pages 50-51
- Service Coordination- Pages 55-56
- NH Transition – Page 57
- CHC-MCO and BH-MCO Coordination – Pages 57-58
- Provider Dispute Resolution Pages 73-74
- Claims Processing – Pages 115-118
- NF Payments/Medicare Deductibles and Coinsurance– Pages 121-122
- Penalty Periods/Third Party Liability- Pages 123-124
- Appendix 4 – Pages 167-170
- Covered Services – Pages 171-172
- Specialized Medical Equipment – Page 194
- Exhibit C – Regulations that DON’T apply to CHC-MCOs- Pages 220-229
- Exhibit F QM/UM Program Measures – Pages 247-268
There are provisions in the agreement that address participant rights, participant handbooks etc, that may also be helpful to review as the Department moves forward with implementation.

2. CHC-MCO Contact Information:
   a. AmeriHealth /Keystone
      i. www.amerihealthcaritaschc.com
         CHCProviders@amerihealthcaritasCHC.com (Phase 1 Zone- Southwest)
      ii. Keystone First www.keystonefirstchc.com
         CHCProviders@keystonefirstCHC.com (Phase 2 Zone – Southeast)

   b. PA Health & Wellness
      i. www.PAHealthWellness.com
         information@pahealthwellness.com

   c. UPMC Community HealthChoices
      i. www.upmchealthplan.com/chc CHCProviders@UPMC.edu

3. Other Resources:
   o PHCA Website: www.phca.org
   o Community HealthChoices Website: www.healthchoices.pa.gov
   o Independent Enrollment Broker: www.enrollchc.com 1-844-824-655
   o The Department created a “For Provider” page on the DHS website
     http://dhs.pa.gov/citizens/communityhealthchoices/ForProviders/index.htm
     The “For Provider” will contain provider resources and communication to assist
     providers in the transition to Community HealthChoices.

Quality Strategy

DHS is required by CMS to submit a Quality Strategy that will serve as a road map for the state and the managed care organizations to assess and improve the quality of services.

- The key components of DHS’s quality strategy include the following:
  - Readiness Review
  - Monitoring and Compliance
  - Network Standards
  - Grievances and Appeals
  - Critical Incidents
Three Phases of CHC Monitoring: Readiness Review, Launch and Steady State

**Readiness Review:** Measures the readiness of the MCO prior to CHC going live. Reviews are completed as desk and on-site reviews and will include all LTSS components. Issues identified during the process will be required to be addressed and resolved prior to the MCO going live.

- MCOs must demonstrate compliance with the implementation of specific policies and procedures, including but not limited to:
  - Administrative functions
  - Enrollment related functions
  - Member Services
  - Service Provisions
  - Network Adequacy
  - Continuity of Care
  - Grievance, Appeal and Fair Hearing Process
  - Critical Incident Monitoring and Reporting
  - Quality Assurances
  - Systems Testing
  - Program Integrity
  - Encounter Data and Financial Functions

- MCOs must also demonstrate coordination with various entities such as:
  - Behavioral Health MCOs
  - Independent Enrollment Broker
  - Financial Management Services

The Department will use a web-based Enterprise Content Management system – DocuShare- as the main source of communication and exchanging of information between the Department and the CHC-MCO plans.

**Launch Monitoring:** Purpose is to ensure continuity for providers and consumers during the transition to CHC.

- The following key indicators will be monitored:
  - Are participants enrolled and receiving LTSS services without interruption
  - How is the Service Coordination process functioning?
Are LTSS providers continuing to deliver services and receiving timely and accurate payment?

Network adequacy – are networks robust and adequate to support the needs of the participants?

Effectiveness and adequacy of communication to stakeholders- both participants and providers- do they have the information they need?

**Early implementation monitoring will include:**
- Daily OLTL team meetings to provide
  - Direct interaction and oversight
  - Rapid decision making to address critical issues
  - Assignment of less urgent issues to appropriate staff
  - Review launch dashboard – weekly – and ad hoc data as available
- Daily update meetings with MCOs
- Daily monitoring of enrollment, consumers and provider hotlines, and Enterprise Incident Management system
- Monitoring services and claims
- Monitoring complaints and grievances
- Short-term implementation reports from the University of Pittsburgh

**Steady State Monitoring:** Purpose is to provide continuous monitoring and program improvement. This will occur after statewide implementation of CHC.

- Plan is to evaluate the following:
  - Lessons learned from readiness review/launch and how to apply in later phases
  - Consumer and provider contacts and complaints to determine areas requiring corrective action
  - Recommend contract amendments and clarifications on common compliance issues

**Evaluation Plan for CHC**

A multi-year evaluation of CHC will be conducted by the University of Pittsburgh. The purpose of the evaluation is to provide an independent assessment of the implementation and outcomes of the program that will complement other oversight and quality assurance activities that will be conducted by DHS. The following broad questions will be addressed for all target groups:

- Does CHC result in greater access to home and community based LTSS and shift the balance of care away from institutional settings for people who prefer to live in the community?
- Does CHC improve coordination of LTSS, physical health care and behavioral health care?
• Does CHC improve the quality of care and quality of life of participants and family caregivers?
• Does CHC lead to innovation in the delivery of physical health care and LTSS?
• Does CHC reduce unnecessary utilization of services and reduce the growth in aggregate costs?

Link to the Evaluation Plan:

The link to the Department’s CHC webpage: