Community HealthChoices: Using Managed Care to Deliver Medicaid-Funded Long-Term Services and Supports (LTSS) in Pennsylvania

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Introduction

Community HealthChoices is an enormous transformation impacting nearly half a million Pennsylvanians, some of who have complex care needs; needs that require more than half of the state's Medicaid budget.

This document summarizes key elements of Pennsylvania's approach for managed long term services and supports. It was prepared from our professional experience with the Medicaid program and it references materials publicly available on Pennsylvania's Community HealthChoices website. Hyperlinks and citations to original sources are embedded throughout the document. Readers are strongly encouraged to read relevant statutes, regulations, bulletins, and contracts themselves for details.

Overview of Community HealthChoices

Pennsylvania is one of a growing number of states placing the responsibility for providing Medicaid-funded long-term services and supports (LTSS) to seniors and people with disabilities under managed care organizations (MCOs). This approach offer both significant risks and considerable opportunities.

Pennsylvania's program, called Community HealthChoices (CHC) is mandatory for dual-eligible individuals (those eligible for both Medicare and Medicaid) and individuals with physical disabilities. Starting in 2018, these populations will begin to move out of a fee-for-service (FFS) system, where the commonwealth pays each provider for delivered services. In the new managed care system, the commonwealth contracts with managed care organizations (MCOs) and pays each a fixed fee (also called capitation payment) for each participant.[1] The MCO is responsible for developing a provider network to ensure that the care is coordinated and participants receive medically necessary services.[2]

Pennsylvania already uses managed care for nearly 2.1 million recipients in physical health and behavioral health today. This program, called

[1] "Participant" is used interchangeably with member, beneficiary, recipient, enrollee and consumer.
[2] For a comparison between FFS and managed care for MLTSS visit the Community HealthChoices website.

HealthChoices, includes all low-income children and adults between 21 and 65 years of age.

Community HealthChoices will totally transform how Medicaid services will be delivered and paid for 420,000 Pennsylvanians, including 130,000 who are currently receiving LTSS in the community and in nursing facilities.

The prospect of changing how LTSS is authorized and financed can understandably cause anxiety among beneficiaries who fear that long standing relationships with providers who assist them in living independently may be at risk. Also, although many LTSS beneficiaries advocate effectively for themselves, the high prevalence of cognitive impairment, low literacy, and limited English proficiency in the Medicaid LTSS population elevates the importance of ensuring that all beneficiaries understand the effect of program and benefit changes. In addition, beneficiaries who receive LTSS include people with disabilities who may require alternative formats or other accommodations for communication to be accessible and effective.

Community HealthChoices also poses practical challenges for MCOs since most of them have much more experience with providing and coordinating medical services geared to treating or curing illness than with providing long-term services and supports to foster and support independent living.

Pennsylvania must operate Community HealthChoices Program in compliance with regulations by the Centers for Medicare and Medicaid Services.[3] The federal government has approved both of Pennsylvania's applications to create and implement the program. One application (1915b) allows the state to operate CHC as a managed care program, but it must do so without putting

[3] In 2016 the Centers for Medicare & Medicaid Services (CMS) issued final regulations that revise and significantly strengthen existing Medicaid managed care rules. In keeping with states' increasingly heavy reliance on managed care programs to deliver services to Medicaid beneficiaries, including many with complex care needs, the regulatory framework and new requirements established by the final rule reflect increased federal expectations regarding fundamental aspects of states' Medicaid managed care programs.

anyone on a waiting list. The other application (1915c) allows the state to offer home and community-based services to older adults and people with physical disabilities.

The Mandatory Enrollment Categories for Community HealthChoices

Adults older than age 21 in the following categories are required enroll in Community HealthChoices:[4]

- Those receiving both Medicare and Medicaid (dual eligibles), regardless of whether they receive LTSS
- Those receiving long-term care waiver services through the Aging,[5] Attendant Care,[6] Independence[7] or COMMCARE[8] waivers
- Those determined nursing facility clinically eligible and in a nursing facility paid for by the state or in the OBRA[9] waiver

Not included in Community HealthChoices are the following adults:

- Those in a state-operated nursing facility or veterans' home
- Those with intellectual disabilities receiving services paid by DHS' Office of Developmental Programs.
- Those in the Living Independence for the Elderly Program (LIFE)
- Those remaining in the state's OBRA waiver program

[4] Historical enrollment data for Community HealthChoices can be found at: http://www.healthchoices.pa.gov/info/resources/publications/community/historical-data-summary/index.htm

[5] For Aging waiver eligibility and services, see: http://www.dhs.pa.gov/citizens/alternativestonursinghomes/agingwaiver/

[6] Act 150 and Attendant Care waiver services are the same.

[7] For eligibility and services for the Independence Waiver, see: http://www.dhs.pa.gov/citizens/alternativestonursinghomes/independencewaiver/

[8] For eligibility and services for the COMMCARE waiver, see: http://www.dhs.pa.gov/citizens/alternativestonursinghomes/commcarewaiver/

[9] For eligibility and services for the OBRA waiver, see: http://www.dhs.pa.gov/citizens/alternativestonursinghomes/obrawaiver

The LIFE Program as an Alternative to Community HealthChoices

Dual eligibles meeting the nursing facility level of care criteria may choose to receive services from LIFE in lieu of Community HealthChoices. The LIFE Program combines Medicaid and Medicare funding in a managed care program that provides comprehensive health and support services to seniors (over 55) who wish to live in their homes. The LIFE program provides home and transportation services, and a day center where participants can receive meals and health care and participate in activities. Eligibility and benefits for the LIFE Program can be found at:
http://www.dhs.pa.gov/citizens/alternativestonursinghomes/lifelivingindependenceforthеelderly/

LIFE Program locations and contact information can be found at:
http://www.dhs.pa.gov/cs/groups/webcontent/documents/document/c_221948.pdf

Community HealthChoices Benefits

There is no decrease in the benefits previously provided with the change to Community HealthChoices, and pest eradication has been added.[10] LTSS Benefits can be viewed at:
http://www.healthchoices.pa.gov/cs/groups/webcontent/documents/document/c_264103.pdf

Medicaid State Plan Behavioral Health Services are excluded from Community HealthChoices' Covered Services. No mental health or drug and alcohol services will be covered by the CHC-MCOs. Everyone going into CHC will receive their Medicaid behavioral health coverage from their county's behavioral health plan. This will be new to people who have been in the Aging Waiver and to nursing home residents.[11]

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[10] See:
http://www.healthchoices.pa.gov/cs/groups/webcontent/documents/document/c_264102.pdf

[11] For the behavioral health plans by county, see:
http://www.healthchoices.pa.gov/providers/about/behavioral/index.htm

Important note: If the CHC participant accessing behavioral health services is a dual eligible, the provider will bill Medicare first and then the Medicaid behavioral health plan. The CHC-MCO will be required to coordinate behavioral health services.

Medicare and Community HealthChoices

Dual eligibles moving to Community HealthChoices will continue to have Medicare as their primary coverage. Their mandatory move to CHC is only changing their secondary Medicaid coverage.

Dual eligibles continue to have Medicare plan choices.[12] They can either:

- Receive Medicare Part A and Part B services through the **Original Medicare Program,** and join a stand-alone **Prescription Drug Plan** or
- Receive Part A and Part B services from a **Medicare Advantage Plan,** private insurance companies that provide all Part A and Part B services and may provide prescription drug coverage and other supplemental benefits.

Community HealthChoices plans must have a Medicare-approved Dual Special Needs Plan (D-SNP plan), but consumers are not required to enroll in that Medicare D-SNP. Again, if a dual eligible is happy with her current Medicare coverage, she can keep the Medicare coverage she has. Even when dual eligibles are enrolled in a Medicare D-SNP affiliated with CHC plan, Medicaid is still their second, separate insurance coverage.

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[12] Reminder that Medicare consists of four different parts:

- **Part A** – Hospital insurance (inpatient hospital care, inpatient care in a Skilled Nursing Facility, hospice care, and some home health services)
- **Part B** – Medical insurance (physician services, outpatient care, durable medical equipment, home health services, and many preventive services)
- **Part C** – Medicare Advantage (MA) (Medicare-approved private insurance companies provide all Part A and Part B services and may provide prescription drug coverage and other supplemental benefits). Dual Special Needs Plans are private insurance plans that only enroll Medicare beneficiaries who also have Medicaid (dual eligibles).
- **Part D** – The Prescription Drug Benefit (Medicare-approved private companies provide outpatient prescription drug coverage).

If the CHC participant accessing behavioral health services is a dual eligible, the provider will bill Medicare first and then the Medicaid behavioral health plan. For services covered by Medicare, the Medicare provider must be enrolled in the Medicaid program, but need not also be in the behavioral health plan network to get paid. If the dual eligible participant is trying to access a service not covered by Medicare (for example, intensive outpatient drug & alcohol services or mobile mental health treatment), their Medicaid behavioral health plan will be their only coverage and so they must go to providers within their plan's network and follow any other rules the plan has for their plan to cover the service.

Finally, CHC plans are expected to coordinate services between Medicare and Medicaid covered services regardless of the type of Medicare coverage. It remains to be seen whether and how CHC plans will meet this service coordination expectation, especially when the CHC participant selects a Medicare plan that is not aligned with their CHC plan--i.e., either Original Medicare or a different Medicare Advantage Plan.

The Community HealthChoices Plans

The commonwealth selected three managed care organizations to serve enrollees across Pennsylvania. All three CHC-MCOs will have to develop a LTSS network across the state, starting with the Southwest zone:

1. **AmeriHealth Caritas** is a Pennsylvania-based non-profit company providing coverage in 14 states for 5.7 million people. It has operated a HealthChoices MCO in Pennsylvania for a long time, although not in every region of the state. Although it provides LTSS in other states, it has not done so in Pennsylvania.

   It is worth noting that in November 2017 AmeriHealth Caritas' voluntarily withdrew from providing services in Iowa. AmeriHealth Caritas covered more than 23,400 out of nearly 37,400 members receiving LTSS, while the other MCOs Amerigroup and UnitedHealthcare covered roughly 7,600 and 6,300 members, respectively.

2. **Pennsylvania Health and Wellness** (Centene) is a publicly traded company that operates in 14 states, serving 12 million people. It has

grown to become the largest Medicaid managed care plan in the country. It has experience operating LTSS MCOs in other states, but it is new to Pennsylvania and will have to develop LTSS and physical health networks across the state.

3. **UPMC for You** is a Pennsylvania based non-profit company owned UPMC by UPMC, a hospital and health care system. UPMC for You has primarily served HealthChoices enrollees in the western part of the state, although it has expanded to other parts of the state. UPMC for You does not have experience providing LTSS.

Regional Rollout of Community HealthChoices

The five zones for Community HealthChoices match Pennsylvania's Physical HealthChoices zone. CHC will be implemented according to the following schedule:[13]

- Southwest Region (14 counties): January 1, 2018
- Southeast Region (5 counties): January 1, 2019
- Lehigh/Capital, Northwest and Northeast Regions (48 counties): January 1, 2020

Enrollment & Plan Selection in Community HealthChoices

Pennsylvanians being moved to CHC will receive information about enrolling in a CHC plan at least 45 days before having to choose one of the three CHC MCOs. If these individuals do not make a plan choice by the deadline, the state will pick a CHC plan for them.

Nearly half of the affected population in the Southwest zone (40,000 out of 80,000 participants) chose a CHC plan for themselves by the initial enrollment deadline of November 13. The rest were auto-assigned to one of the three CHC plans available: AmeriHealth Caritas, PA Health & Wellness or UPMC.

[13] See: http://www.healthchoices.pa.gov/cs/groups/webcontent/documents/document/c_237795.pdf for list of counties in each HealthChoices region.

Individuals who did not choose could still select a CHC-MCO after the November 13th deadline. If they enroll in a plan before the end of the year, their plan choice will start on January 1st and will override any plan assignment made by the state.

Significantly, individuals in Community HealthChoices are not "locked in" to a CHC plan. Similar to the state's Physical HealthChoices program, Community HealthChoices consumers can **change MCOs whenever they need to** without having to go through a formal process of proving they have a good reason to change plans. This singular freedom of choice feature of enrollment, plan selection, and disenrollment is an important and distinguishing feature of Pennsylvania's MLTSS approach.

Continuity of Care for Enrollees When HealthChoices Begins

Continuity of care is particularly important for CHC participants receiving long-term services and supports, and for that reason CHC participants can remain with their current LTSS provider for a limited period of time.

Community HealthChoices includes the following continuity of care provisions to minimize interruptions in care when HealthChoices begins in a region:[14]

- Any person residing in nursing facility when Community HealthChoices is implemented in a region may continue to live at the facility as long as they are enrolled in Community HealthChoices, unless the facility drops out of the Medicaid Program. A temporary hospitalization or change in Community HealthChoices MCO does not change this as long as the person is considered a resident of the facility.
- For persons receiving home and community based waiver services, the CHC-MCO must continue to reimburse those providers for 180 days or until a comprehensive needs assessment has been conducted and a person-centered service is plan is created, whichever is later.
- After that 180-day period ends, the CHC plan can require their members use waiver providers that are "in-network" with the plan. The plan could

[14] The Bulletin regarding continuity of care when transferring between MCOs can be found at: http://www.dhs.pa.gov/publications/bulletinsearch/bulletinselected/index.htm?bn=99-03-13

also revisit the person's service plan and decide to reduce, change or terminate a service. If this happens, the individual can appeal the plan's decision.

- The 180-day continuity of care provision ending date for new zones implementing CHC is
    - June 30, 2018 for Southwest
    - June 30, 2019 for Southeast
    - June 30, 2020 for Lehigh Capital, NW and NE

The Agreement between the State and Community HealthChoices MCOs

The contract between Pennsylvania and the CHC-MCOs is a critical and lengthy document that sets forth the requirements CHC-MCOs must provide for all covered services and related services to Participants. We have summarized some of the most significant provisions of the 350+ page Agreement. The final agreement was not publicly available at the time of publication but will be posted to the CHC website.

The term of the Agreement is five years starting January 1, 2018, with a state option to renew for two years. Given the staggered regional implementation, unless the contract is extended, it would be in effect in SW for 5 years, SE for 4 years and the rest of the state for only 3 years.

Program Requirements

National Accreditation. All CHC-MCOs must be accredited by the National Committee for Quality Assurance (NCQA), a not-for-profit organization dedicated to improving health care quality or by another national accreditation body. Plans not accredited at the start of the contract have until the end of the second calendar year of the contract to do so. Once accredited, plans must maintain accreditation throughout the contract. Note that NCQA does not have accreditation for LTSS, but is reported to be working on one. So, the accreditation is only for the medical/clinical aspects of the MCO, not LTSS.

D-SNP Program. CHC-MCOs must have a Medicare-approved Dual Special Needs Plan (D-SNP plan) in operation by the start of implementation in each zone. The D-SNP plan must enter into a MIPPA Agreement with the state, which must be approved by CMS.

For MIPPA requirements visit: http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downlods/mc86c16b.pdf

The agreement between the state and all D-SNP plans can be found here: http://www.healthchoices.pa.gov/info/resources/publications/community/mippa-documents/index.htm

Standard for Long-Term Services and Supports (LTSS)

CHC Plans must assure that all covered services are medically necessary, which is defined in the Agreement as meeting any one of the following standards:

- Will, or is reasonably expected to, prevent the onset of an illness, condition or disability
- Will, or is reasonably expected to, reduce or ameliorate the physical, mental or developmental effects of an illness, condition, injury or disability
- Will assist a Participant to achieve or maintain maximum functional capacity in performing daily activities, considering both the functional capacity of the Participant and those functional capacities that are appropriate for Participants of the same age
- Will provide the opportunity for a Participant receiving LTSS to have access to the benefits of community living, to achieve person-centered goals, and live and work in the setting of his or her choice.

Medical necessity must be "based on medical information provided by a Participant, the Participant's family or caretaker and PCP, as well as other Providers, programs or agencies that have evaluated the Participant. A determination of Medically Necessary services must be made by qualified and trained Providers with clinical expertise comparable to the prescribing Provider.

The medical necessity definition becomes critical when representing enrollees challenging reductions in services and denial of services prescribed by their providers. See section below.

Amount, Duration and Scope of LTSS

CHC plans "must provide services that are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished". Services are listed in Appendix A of the Agreement. Home and community-based services must be available 24-hours a day/seven days a week.

CHC-Plans can do more than the minimum. Plans are encouraged to offer LTSS as expanded services to enrollees who are not Nursing Facility Clinically Eligible (NFCE). MCOs may provide "individually tailored services" in addition to the covered services when they are identified by the person-centered screening process are appropriate to support the enrollee in the community.

Pharmacy services. The CHC-MCO must provide pharmacy services and over the counter drugs to duals that are not covered by Medicare Part D and pharmacy services for all other enrollees. The MCO must offer assistance to enrollees to choose a Medicare Part D plan with zero co-pay.

Transportation Services

Given the high needs of the CHC population and the trend toward greater use of non-medical benefits, non-emergency medical transportation is an important part of Community HealthChoices. The Agreement states that the Medical Assistance Transportation Program (MATP), which is primarily county based, is responsible for the following:

- Non-emergency transportation to a medical service that is covered by Medicare or CHC. This includes transportation for urgent care appointments. Participants whose service is paid by Medicare can receive MATP service.

- Transportation to another county, as medically necessary, to get medical care as well as advice on locating a train, bus, and route information.

- Reimbursement for mileage, parking, and tolls with valid receipts, if the Participant used her own car or someone else's car to get to the Provider.

CHC-MCOs also bear some transportation responsibilities. The CHC-MCO must provide all NFCE Participants with non-medical transportation. 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 may provide non-medical transportation to other Participants at its own discretion and own cost.

Finally, the Agreement states the CHC-MCO must provide non-emergency medical transportation for nursing facility residents, including transportation for NF residents who are stretcher-bound. However, it is unclear whether CHC-MCOs must provide transportation when the NF residents medical service is covered by Medicare.

Nursing Facility Services

CHC-MCO requirements for nursing facility payments, including bed hold and therapeutic leave days are set forth in the Agreement. CHC-MCOs are required to contract with any nursing facility enrolled in Medicaid that accepts the MCO's payment rate and complies with quality assurance requirements for 18 months. The state may require this time to be extended.

Enrollee Self-Directed Services

CHC-MCOs must offer its members eligible for LTSS, the opportunity to self-direct personal assistance services, instead of the traditional MCO model of using an agency. Under this model, enrollees may employ any "state qualified" personal assistant to provide care including a family member or neighbor.

Settings for LTSS

These services must be provided in the least restrictive and most integrated setting. If NFCE enrollees are living in settings at time of implementation that do not comply with state law, such as personal care homes, they will be allowed to remain there while in CHC.

Service Delivery Innovation

The agreement requires CHC-MCOs to work with the state and other collaborations on service delivery innovation, particularly with housing.

Prior Authorization of Services

CHC-MCOs may require prior authorization for any service where it is required under FFS, but must have written policies approved by the state. Exhibit E of the Agreement contains the guidelines for prior authorization and other requirements.

Denials of requested services must be in writing and in accessible formats for persons with disabilities, the visually impaired and persons with limited English proficiency. CHC plans must process requests for prior authorization within two business days or faster if the enrollee's health requires it with written notice to the enrollee, the enrollee's Primary Care Physician (PCP) and the prescribing provider.

If the CHC plan requests additional information, and it is received within 14 days, the plan must make a decision within 2 business days of the receipt of the information. If the requested information is not received within 14 days of the request, the plan must approve or deny the service based on the information that is available. If the enrollee has not received a decision within 21 days of the request for prior authorization, the requested service is deemed automatically approved.

The CHC plan will be considered to have met the notice requirement if the notice is mailed to the enrollee and providers within 18 days of the request. If the enrollee is receiving the services subject to the prior authorization request, the CHC-MCO must mail written notice of denial at least ten days before the effective date services will be denied.

General Continuity of Care Requirements Other Than Those When CHC Starts in a Region

If a person transfers to a different MCO six months after implementation in a region, the receiving MCO must continue paying the consumer's providers for 60 days or until a comprehensive needs assessment has been conducted and a person-centered service is plan is created, whichever is later.

- Persons admitted to a nursing facility after the implementation of Community HealthChoices will have the standard 60 days of continuity of care.
- If an enrollee is receiving LTSS has a provider who leaves the plan network, the CHC MCO must continue to allow the enrollee to receive services from that provider for 60 days, pay the provider, until alternative provider services can be arranged.

Choice of Provider

Enrollees must have a choice of providers, including service coordinators within the plan network and the MCO may not try to influence this choice.

Functional Assessments for Long Term Services and Supports

For individuals to receive Medicaid-covered LTSS, they must be determined nursing facility clinically eligible (NFCE). This means an individual must meet the state's defined functional eligibility criteria, which are based on physical and cognitive abilities. To determine whether an individual meets the state's functional eligibility criteria, Pennsylvania uses sets of questions that collect information on an applicant's health conditions and functional needs. CHC plans are <u>not</u> involved in this determination.

The CHC-MCO must conduct a comprehensive needs assessment of every Participant who is determined NFCE. The state is requiring CHC MCOs to use the InterRAI HC[15] tool for this assessment. This is far more intensive and takes longer than the NFCE determination. It includes physical and behavioral health, social,

[15] InterRAI is a collaborative network of researchers and practitioners committed to improving care for persons who are disabled or medically complex. The University of Michigan provides significant research support for this organization and the development of assessment tools. InterRAI survey instruments cover a range of assessments including but not limited to the determination of clinical or functional limitations, the identification of unmet needs, and the match of services with needs to support the requirements of assessed individuals.

psychosocial, environmental, caregiver, LTSS and other needs, including the CHC participant's stated preferences, goals, housing and informal supports.

The information from the comprehensive needs assessment informs the amount and scope of LTSS. The CHC-MCO is responsible for developing a Person-Centered Service Plan (PCSP) for every CHC participant who requires LTSS. That plan must address how the enrollee's physical, cognitive and behavioral health needs will be managed and coordinated with Medicare coverage (if applicable) and coordinated with the LTSS. The components of the Care Management Plan and LTSS Plan are listed the Agreement and must be completed no more than 30 days from the date of the comprehensive needs assessment.

If the Participant has <u>not</u> been determined NFCE, then the CHC-MCO must conduct a comprehensive assessment of a Participant when the Participant requests a comprehensive assessment or self-identifies as needing LTSS or if either the CHC-MCO or the Independent Enrollment Broker (IEB) identifies that the Participant has unmet needs, service gaps, or a need for Service Coordination.

The Agreement has hard deadlines for when comprehensive needs assessments must be done:

- within 5 days for NCFE enrollees not receiving LTSS on enrollment date.
- within 5 days for dually eligible enrollees identified by the independent enrollment counselor as needing immediate services.
- within 15 business days of the CHC-MCO being aware that an enrollee has unmet needs, service gaps or a need for a Service Coordinator
- within 90 days of enrollment for those not NCFE, the CHC-MCO must do an assessment for unmet needs such as: health care needs needing chronic or disease management, service gaps or need for service coordination.
- within 180 days of the start date for enrollees with existing person centered service plans
- within 15 days when requested by enrollees, their designee or family member
- within 12 months following the most recent comprehensive needs assessment unless a triggering event occurs

- within 14 days of a triggering event or earlier if the circumstances or clinical condition requires a quicker response
- every 12 months for those with a need for service coordination and must include assessment of physical and behavioral health, "social, psychosocial, environmental, caregiver, LTSS and other needs as well as preferences, goals, housing and informal supports"
- Reassessments must also be done within 14 days of a triggering event, which includes a hospitalization, change in functional status, change in caregiver of informal supports or home setting that impacts health or functional status, non-temporary or episodic change in diagnosis that impacts health or functioning, a request by the enrollee, designee, caregiver a provider, or the state

Service Coordinators

Service coordination is a core component of Community HealthChoices. Service Coordinators lead the Person-Centered Service Plan (PCSP) process, oversee their implementation and assist enrollees needing LTSS to obtain the services they need. The CHC-MCOs must annually submit a PCSP staffing plan for service coordination for approval by the State, that includes staffing ratios, and after-hours and emergency staffing, frequency of contact and how real time information about enrollees will be received and shared, including patient encounters. The CHC-MCO must provide enrollees with a choice of at least two service coordinators.

Nursing Home Transition Unit

All MCOs must have a nursing home transition unit to work with nursing home resident enrollees who wish to transition back to the community. Some enrollees in nursing homes will not be able to transition back to the community and keep their Medicaid coverage for LTSS because under MA eligibility rules, nursing home residents who have income over the MA limit may use that income to "spend down" to pay for the nursing home care until they reach the MA income level. Spend down is not permitted for LTSS in the community.

Coordination of Physical and Behavioral Health

HealthChoices uses different MCOs to provide behavioral health services and this separation continues with Community HealthChoices. The contract requires the CHC MCO to enter into a coordination agreement with the BH MCO, which must be approved by the State. MCOs must use information exchanges with

data provided by the State to control avoidable hospital admissions and readmissions and ER data for enrollees with serious mental illness, substance abuse disorder or both and coordination mechanisms to reduce the use of psychotropic medications prescribed to enrollees.

Enrollees can enroll in a different MCO or the LIFE Program and the MCO is prohibited from preventing or restricting an enrollee from make these changes. The MCO must participate in discharge planning for 6 months after the enrollee has left the plan. The agreement has clear standards about MCO outreach materials and enrollment materials, requirements for development of outreach materials to be used by the independent enrollment counselor and enrollee handbooks, and prohibited marketing activities by MCOs (e.g., "products of value" given to enrollees or prospective enrollees).

Limited English Proficiency (LEP) Requirements

MCOs are required to identify LEP enrollees and provide, at no costs to enrollees oral interpretation services to LEPs, and interpretative services to those who are deaf and/or blind and alternate format materials and materials in languages designated by the State.

Alternative Format Requirements

The MCO must provide alternative methods of communication for enrollees who have neurocognitive impairments or who are visually and/or hearing impaired, including Braille, audio tapes, large print, discs, special support services, electronic communication, etc.

Participant Advisory Committee

Each CHC-MCO must establish an Advisory Committee for each CHC zone that includes enrollees, providers, and direct care work representative. The enrollee representative must reflect the population being served, geographic representation and family members, with provider representatives that include physical, behavioral and dental health and LTSS. Sixty percent must be enrollee representatives, with 25% receiving LTSS. In-person meetings must be at least quarterly with MCOs reimbursing for travel and accommodation expenses.

Participant Services

Enrollees must be able to reach the plan during regular business hours (9:00AM-5:00PM, Monday through Friday) plus one evening (5:00 PM-8:00PM or one

weekend per month) to address non-emergency problems and arrangements to be able to reach the MCO for emergency enrollee problems 24 hours a day, 7 days a week.

Dedicated Hotline. The MCO must staff a 24-hour a day 7 day a week dedicate toll-free hotline to respond to enrollee's issues and problems regarding services. Callers must be asked if they are satisfied with the respond and if not the enrollee must be referred to the appropriate person in the MCO for follow-up and resolution within 48 hours.

Nurse Hotline. MCOs must also staff a nurse hotline 24 hours a day, seven days a week to deal with enrollee's urgent health needs.

Complaint, Grievance, and Fair Hearing Processes

All CHC plans have certain responsibilities related to notifying their members (enrollees) of appeal rights. If a CHC-MCO plan denies service or payment, in whole or in part, the CHC plan is required to provide the enrollee with a written notice of its determination. Additionally, enrollees receiving covered services (e.g., inpatient hospital, home health agency, or comprehensive outpatient rehabilitation) have the right to a fast, or expedited, review if they think their Medicaid -covered services are ending too soon. The CHC-MCO *must* also continue the enrollee's services if the appeal is filed timely.

Exhibit G of the Agreement between the state and MCOs details the processes each plan must follow[16]. We summarize some the core elements below:

[16] Federal regulations set forth the requirements for beneficiary support for LTSS. See: 42 C.F.R. 438.71. They include:
(1) An access point for complaints and concerns about plan enrollment, access to covered services, and other related matters.
(2) Education on grievance and appeal rights within the plan; the fair hearing process; enrollee rights and responsibilities; and additional resources outside of the plan.
(3) Assistance, upon request, in navigating the grievance and appeal process within the plan, as well as appealing adverse benefit determinations by the plan to a fair hearing. (no representation, but only referral at fair hearings)
(4) Review and oversight of LTSS program data to provide guidance to the DHS on identification, remediation and resolution of systemic issues.

At the outset, each CHC-MCO must obtain the Department's prior written approval of its complaint, grievance and fair hearing policies and procedures.

Recordkeeping Requirements**:** Each CHC-MCO must maintain accurate written records of complaints and grievances. The state will review the information as part of its ongoing monitoring. The plan's records must be accessible to the state. An enrollee's appeal record must, at least, contain: (1) a general description of the reason for the complaint or grievance; (2) date received; (3) date of review; (4) resolution; (5) date of resolution; and (6) name of the enrollee for whom the complaint or grievance was filed.

CHC-MCO must also satisfy the state that there are protections in place for oral appeals, to ensure that the appeal is acknowledged and the resolution timeframe runs from the date the oral appeal is received by the managed care plan.

Complaints vs. Grievances: Enrollees can file either complaints or grievances, depending on the nature of the disagreement. And assuming written consent of the enrollee, a provider or authorized representative may file a complaint or grievance on the enrollee's behalf.

Complaint: A complaint allows enrollees to express dissatisfaction with matters that are not adverse benefit determinations, such as being treated rudely. In simplest terms, and as noted in the CHC-MCO's member handbook, a complaint is triggered "if you are unhappy about the care or treatment you have received."[17] According to the Agreement, Complaints also include enrollees' disputes over an extension of time proposed by a CHC-MCO to make an authorization decision. It can include enrollees' disputes involving "cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities."

[17] The member handbook template the state has instructed CHC-MCOs to use states: "A Complaint is when you tell [CHC-MCO Name] you are unhappy with [CHC-MCO Name] or your provider or do not agree with a decision by [CHC-MCO Name]. Some things you may complain about: you are unhappy with the care you are getting, you cannot get the service or item you want because it is not a covered service or item, you have not gotten services that [CHC-MCO Name] has approved."

Grievance: The event that triggers a grievance is an "adverse benefit determination." Again, in simplest terms, and as noted in the CHC-MCO's member handbook, a grievance is "When [CHC-MCO Name] denies, decreases, or approves a service or item different than the service or item you requested because it is not medically necessary." Grievances are about the denial, reduction, suspension, termination or delay of a covered service. In addition to denials based on medical necessity, grievances can be denials or limited authorization determinations of a covered benefit based on appropriateness, setting, or effectiveness.

More about the Complaint Process: Some complaints have a time limit on filing. Enrollees must file a complaint within 60 days of getting a written notice that states:

- a denial because the service or item is not a Covered Service;
- the failure of the CHC-MCO to provide a service or item in a timely manner;
- the failure of the CHC-MCO to decide a Complaint or Grievance within the specified time frames;
- a denial of payment after the service or item has been delivered because the service or item was provided without authorization by a provider not enrolled in the Medicaid Program;
- a denial of payment after the service or item has been delivered because the service or item provided is not a covered service for the participant; or
- a denial of a participant's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other participant financial liabilities.

For all other complaints, there is no time limit for filing a first level Complaint.

Enrollees who file complaints will get a letter from the CHC-MCO acknowledging receipt of the complaint and describing the complaint review process. **There are two levels of complaints: a first level and a second level**. Both use the same procedures. Enrollee attendance is optional. Enrollees can attend the complaint review in person, by phone, or by videoconference. If an enrollee decides not to attend the complaint review, it should not affect the decision.

A committee of one or more CHC-MCO staff who were not involved in and do not work for someone who was involved in the issue the enrollee has filed the complaint about will meet to make a decision. If the complaint is about a clinical issue, a licensed doctor will be on the committee.

Enrollees can ask the CHC-MCO for any information the CHC-MCO has about the issue filed about at no cost to the enrollee. Enrollees can also send information to the CHC-MCO.

The CHC-MCO must mail the enrollee a decision no more than 30 days from receipt of the enrollee's complaint. The notice will also tell enrollees what to do if they do not like the decision.

More about the Grievance Process: Unlike the complaint process, there is only one level for grievances; however, enrollees must exhaust that grievance before requesting a state fair hearing.

The enrollee must file the appeal within 60 calendar days from the date of the adverse benefit determination notice from the CHC-MCO.

The appeal can be filed orally or in writing (which includes online filing).

CHC-MCOs must have a process for handling grievances that: (1) acknowledges receipt, (2) ensures that the individual who make the decisions on the grievance were neither involved in any previous level of review or decision-making nor a subordinate of any such individual, and (3) are individuals with "appropriate clinical expertise in treating the enrollee's condition or disease," if the appeal involves denial based on no medical necessity.

CHC-MCOs must give the enrollee "any reasonable assistance" in completing forms and other procedural steps to file a grievance, including auxiliary aids, upon request, including providing interpreter services and toll-free numbers that are accessible to people with disabilities.

When deciding the grievance CHC-MCO must take into account all comments, documents, records, and other information submitted by the enrollee, including information that was not submitted to or considered in the initial adverse determination. The plan must also provide the enrollee with a reasonable opportunity, "in person and in writing," to present evidence and make legal and factual arguments. The CHC-MCO must provide the enrollee and his

representative with the case file, including medical records and any new or additional evidence considered or generated by or at the direction of the CHC-MCO in connection with the appeal. This information must be provided free of charge and sufficiently in advance.

CHC-MCOs must resolve grievances as expeditiously as the enrollee's health condition requires. The CHC-MCO must mail the enrollee a decision no more than 30 days from receipt of the enrollee's grievance. These timeframes can be extended by up to 14 calendar days if the enrollee requests it or the CHC-MCO shows to the satisfaction of the state agency that there is a need for additional information and how the extension is in the enrollee's interest.

External Review

If an enrollee is not satisfied with the CHC-MCO's complaint or grievance decisions, she can file for an External Review of the decision outside the CHC-MCO. The enrollee must send a letter to the CHC-MCO within 15 days of the date of receiving the plan's grievance decision. The letter is forwarded to the Department of Health who will assign an organization outside of the CHC-MCO (called a Certified Review Entity or CRE) to review the plan's decision. The CHC-MCO will send the CRE a copy of the enrollee's grievance file to review. The enrollee can also send the CRE any additional information that may support their appeal. The CRE will issue a decision within 60 days of the date the External Grievance was filed. Once a decision is made, a copy will be sent to the enrollee. The letter will tell the enrollee the reasons for the decision and what the enrollee can do if he/she disagrees with the decision.

Expedited Review Process for Grievances

CHC-MCOs must have an expedited review process for grievances. An expedited appeal occurs when the plan determines (for a request from the enrollee) or the provider indicates (in making the request on the enrollee's behalf or in support of the enrollee's request) that taking the time for standard resolution "could seriously jeopardize the enrollee's life, physical or mental health, or ability to attain, maintain, or regain maximum function." CHC-MCOs must ensure that punitive actions are not taken against providers who seek expedited resolutions. If the CHC-MCO denies the enrollee's request, it must process the appeal under the requirements for standard resolution and give the enrollee notice of their right to file a grievance if she disagrees with the decision to deny expedited resolution.

Fair Hearings

In most complaint and all grievance matters, an enrollee can ask the state's Department of Human Services to hold a hearing, called a "fair hearing." They can be requested, in writing, **after** a CHC-MCO decides a first level complaint or decides a grievance. An enrollee must file for a Fair Hearing writing within 120 days from the date of the notice on the CHC-MCOs decision on the first level complaint or grievance.

If an enrollee's doctor believes that waiting for the usual timeframe for a Fair Hearing decision would harm his/her health, the enrollee can request that the Fair Hearing be decided more quickly. The enrollee's doctor will need to certify that waiting 30 days for a decision would jeopardize the consumer's life, health, or ability to attain, maintain or regain maximum function. The Fair Hearing will be held by telephone. As with expedited complaints and grievances, the state must give a decision within 48 hours of when the harm statement is received from the provider, **or** within three business days of the date the request for an expedited process was received, whichever is **shorter.**

Continuation of Benefits Pending Appeal

The CHC-MCO *must* continue the enrollee's services if all of the following occur:

(1) The enrollee files a timely appeal (that is, an appeal is filed within 60 calendar days from the date on the adverse benefit determination notice);

(2) The appeal involves termination, suspension, or reduction of a previously authorized service;

(3) The service was ordered by an authorized provider;

(4) The period covered by the original authorization has not expired; *and*

(5) **The enrollee timely files for continuation of benefits (that is, the enrollee requests continuation of benefits <u>on or before 10 calendar days of the health plan sending the notice of adverse benefit determination</u>).** (This is a very short time for enrollees to figure out the process and file for a continuation of benefits. Note: it is calendar days, not business days and the clock starts running when the notice is sent, not when it is received.)

If these conditions are met, the benefit must continue until the enrollee withdraws the appeal or fair hearing request, the enrollee does not request a state fair hearing within 10 calendar days after the health plan sends notification of its adverse resolution, or the state fair hearing is decided against the enrollee.

Provider Dispute Resolution Processes

These processes must be developed by the MCO, including an informal process and a formal appeal process which handles resolution of all issues regarding the interpretation of the Provider Agreement and does not involve the State. This must be approved by the State prior to the start of CHC. The CHC-MCO must have DOH operating authority as a HMO in each county within the zone.

Executive Management Requirements

- Full-time Administrator with authority over operation of the MCO
- Full-time Medical Director licensed in PA involved in all major clinical program components and oversees the QM and UM Departments and must be available after hours as is needed.
- Full-time Pharmacy Director, licensed as a pharmacist in PA who oversees the pharmacy management and serves on the MCO P&T Committee.
- Full-time Director of Quality Management
- Full-time Director of LTSS responsible for overseeing all LTSS with at least 5 years' experience administering managed LTC programs, or equivalent experience.
- Full-time chief financial officer to oversee budget and accounting systems of the MCO.
- Full-time Information Systems Coordinator, responsible for overseeing all information systems with the State.
- Other Administrative positions include (1) Quality Management/Quality Improvement Coordinator (2) BH Coordinator (3) Director of Network Management (4) UM Coordinator (5) Director of Service Coordination (6)Government Liaison (7) Participant Services Manager (8) Provider Services Manager (9) Provider Claims Educator (10) Complaint, Grievance and the State Hearing Coordinator (11)Claims Administrator (12) Contract Compliance Officer.
- The MCO staffing should represent the racial, ethnic, and cultural diversity of the enrollees being served by the MCO.
- The MCO must have an administrative office in each zone unless an exception has been granted by the State.
- The MCO must submit the organization structure, listing the function of each executive and administrative staff member.

Electronic Visit Verification

The CHC-MCO must have a fully operational Electronic Visit Verification (EVV) system in place for in-home personal care and home health services on a date specified by the Department which records verifies the type of service performed, the enrollee receiving the service, date and location of service and time service begins and ends.

Management Information Systems

Department Access requirements include having an appropriate on-site private office and equipment and the ability to audit any books, records, equipment, etc. at any time. MCOs must keep records for 10 years.

Selection and Assignment of Primary Care Physician

Selection and assignment of a Primary Care Physician (PCP) by an enrollee will first be attempted by the Independent Enrollment Program (IEP), reflecting the enrollee's choice of PCP or PCP group within the MCO network. Dually eligible enrollees are not required to select a PCP from the network, but may designate their Medicare PCP. Non-dually eligible must utilize a network PCP unless permitted under DOH regulations.

- If an enrollee has not selected a PCP through the IEP, except for the exceptions above, the MCO must contact the enrollee within 7 business days of enrollment and provide information and options on selecting a PCP. If the MCO has information that the enrollee has a medical condition requiring immediate care, the MCO should attempt contact at once.
- If an enrollee has not made a selection within 14 business days of enrollment, and the enrollee is dually eligible, the enrollee will be assigned the PCP the enrollee uses in in D-SNP. The plan must take into consideration medical condition, provider relations, language and cultural compatibility, access to transportation, etc. in assigning a PCP and must notify the enrollee by phone and in writing of the PCP name, location and telephone number.

- The MCO must have policies and procedures (approved by the State in advance) to allow the enrollee to change PCPs, change PCPs if they leave the network or as part of a resolution of a grievance or complaint.
- An enrollee may request a specialist as a PCP, which if denied by the MCO is appealable.

Selection and Assignment of Service Coordinators

Selection and assignment of service coordinators must be pursuant to a process for selection and assignment (approved in advance by the State) including:

- offering a choice of Service Coordinators employed or under contract
- contacting the enrollee within 7 business days of the comprehensive needs assessment indicating the need for LTSS to provide options for selection of the service coordinators, unless the MCO has information that the enrollee's medical condition requires more immediate action
- assigning a service coordinator if the enrollee does not select one within 14 business days, considering the same factors listed above for assignment of a PCP and notify the enrollee of the assignment
- permitting a prompt change in service coordinator upon request of the enrollee

Provider Services

Provider services must be provided by the CHC-MCO Monday through Fridays 9:00 AM-5:00 PM to assist providers listed in the Agreement, including enrollee eligibility, prior authorization. Claims, transfer of medical records, out-of-plan services, etc.

Provider Network

The provider network must include all willing and qualified LTSS Providers for the first 180 days of operation with in a CHC zone. Thereafter the MCO may adjust its provider network consistent with network access and adequacy standards in the Agreement in Exhibit U, but must include all covered services. If the MCO network is unable to provide necessary covered services, the MCO must provide these services through out-of-network providers. The MCO must assure that providers meet the minimum qualification requirements and are credentialed

according to state standards. The MCO must have provider agreements with their network providers that meet the requirements outlined in Exhibit T and do not prohibit those providers from contracting with another CHC MCO. The MCO and providers must demonstrate the cultural, linguistic and disability competency.

- A provider that is a related party to a MCO must negotiate in good faith with other MCOs and the state may terminate an agreement with the MCO if it determines that the good faith negotiation requirements have been violated.
- The MCO must prohibit network providers from discriminating or segregating enrollees, including on the basis of MA status.
- The MCO must have policies requiring their network to provide complex interventions except where a competent enrollee objects or has an executed Advanced Healthcare Directive.

Quality Management (QM) and Utilization Management (UM) Program Requirements

QM and UM program requirements are contained in Exhibit F and G and W HEDIS requirements, Exhibit X(3)m External Review in Exhibit X(1). CHC-MCOs may not have compensation or payments to those doing UM activities so as to provide incentives for them to deny, limit or discontinue Medically Necessary services to any enrollee. MCOs must participate in the Medical Assistance Advisory Committee process. MCOs must submit corrective action plans for any quality of care deficiencies identified by the state. The CHC-MCO must cooperate with any research and evaluation activities requested by the state.

Employment Support provisions require the CHC-MCO to refer for services from OVR or other resources for enrollees who indicate they want employment. The CHC-MCO must offer services that lead to securing or obtaining employment including job coaching and finding, etc.

Sanctions

Sanctions for noncompliance or violating the agreement ranges from a fine of $1,000 per day for noncompliance, to requiring corrective action plans, to suspending or limiting enrollment of new enrollees, to suspension of payments to taking over temporary management of the CHC-MCO and termination of the agreement.

Termination and Default

Termination and Default sets forth the grounds for the state termination and allows the CHC-MCO to terminate with 120 days advance notice.