Benefits

Q1. Can more specifics be provided on what behavioral health (BH) services nursing facilities might have available to residents?

A. All CHC participants will be covered by BH managed care through the existing behavioral health managed care organizations (BH-MCOs).

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-MCOs 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.

Q2. Will the CHC-MCO or the Department of Human Services (DHS) approve the exceptional durable medical equipment (DME) requests and who is responsible for maintaining the exceptional DME list?

A. The CHC-MCOs must provide and have a process for approving exceptional DME, as defined in Exhibit A(1) of the CHC Agreement, Covered Services – Long-Term Services and Supports Service Definitions. DHS will continue to publish an annual list of exceptional DME by notice in the Pennsylvania Bulletin in July, which shall be incorporated by reference and supersede the current list of exceptional DME set forth in Exhibit A(1).

Q3. What is the process for the approval of exceptional durable medical equipment (DME) requests and who is responsible for maintaining the exceptional DME list?

A. The CHC-MCOs must provide and have a process for approving exceptional DME, as defined in Exhibit A(1) of the CHC Agreement, Covered Services – Long-Term Services and Supports Service Definitions. The Department of Human Services will continue to publish an annual list of exceptional DME by notice in the Pennsylvania Bulletin in July, which shall be incorporated by reference and supersede the current list of exceptional DME set forth in Exhibit A(1).

The CHC-MCOs must provide a separate payment for exceptional DME in addition to the nursing facility per diem rate. The amount of the additional payment authorized is based upon the necessary, reasonable, and prudent cost of the exceptional DME. Purchased equipment will belong to the participant.
Q4. Will the CHC-MCO honor an existing exceptional durable medical equipment (DME) grant?

A. Any wheelchairs or augmentative communication devices approved prior to January, 1, 2018, the Department of Human Services will be responsible for follow-up and payment. Any bed or mattress rentals that were approved prior to January 1, 2018 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, 2018 but have not been reviewed by the Department will be transitioned to the CHC-MCO for review and payment.

Q5. Will there be coverage for dentures, glasses and hearing aids under CHC?

A. Dentures and eyeglasses for individuals with aphakia are covered physical health services under CHC. Hearing aids are covered through the 1915(c) home and community-based waiver under Specialized Medical Equipment and Supplies.

Individuals may want to contact the CHC-MCO to ask if the CHC-MCO offers dentures, eyeglasses or hearing aids as value-added services.

Q6. What is the difference between adult daily living services and personal assistance services under CHC?

A. Adult Daily Living services are designed to assist participants in meeting, at a minimum, personal care, social, nutritional and therapeutic needs. Adult Daily Living services are generally furnished for four or more hours per day on a regularly scheduled basis for one or more days per week, or as specified in the service plan, in a non-institutional, community-based center encompassing both health and social services needed to ensure the optimal functioning of the participant. Adult Daily Living includes two components: Basic Adult Daily Living services and Enhanced Adult Daily Living services.

Personal Assistance Services (PAS) primarily provide hands-on assistance to participants to enable them to integrate more fully into the community and ensure the health, welfare and safety of the participant. PAS, which are generally provided to participants in their homes and communities, are aimed at assisting participants to complete tasks of daily living that would be performed independently if they had no disability.

A participant’s need for Adult Daily Living Services and PAS are determined by an assessment conducted by the CHC-MCOs, in accordance with the Department of Human Services’ requirements and specified in the participant’s Person-Centered Service Plan (PCSP).
Q7. How will hospice services in a nursing facility be provided and reimbursed under CHC?

A. The CHC-MCOs must provide hospice and use certified hospice providers in accordance with 42 C.F.R. Subpart G. CHC-MCOs will be required to contract with Medical Assistance (MA) enrolled hospice providers to provide these services. To be an MA enrolled provider, the hospice must be a Medicare certified provider. As with other Medicare-covered services, CHC participants will be required to exhaust their available Medicare hospice benefits. The CHC-MCO must coordinate with hospice providers for dual eligible participants who are receiving hospice through their Medicare coverage. Hospice provided to participants by Medicare-approved hospice providers is directly reimbursed by Medicare.

Under CHC, the hospice provider and nursing facility will bill the CHC-MCO for services rendered. The hospice provider will bill the CHC-MCO for any hospice services rendered and nursing facilities will bill the CHC-MCO for the resident’s room and board.

Q8. Are Home and Community-Based Services (HCBS) specialized medical equipment and supplies covered under CHC?

A. The CHC-MCO must provide HCBS specialized medical equipment and supplies. Specialized medical equipment and supplies are services or items that provide direct medical or remedial benefit to the participant and are directly related to a participant’s disability.

Specialized medical equipment and supplies includes: devices, controls or appliances, specified in the Person-Centered Service Plan (PCSP), that enable participants to increase, maintain or improve their ability to perform activities of daily living; equipment repair and maintenance, unless covered by the manufacturer warranty; items that exceed the limits set for Medicaid state plan covered services; and rental equipment. In certain circumstances, needs for equipment or supplies may be time-limited.

Q9. Can you provide a list of covered services to be provided under CHC?

A. Exhibits A and A(1) of the CHC Agreement provide a list of the services covered under CHC.

Q10. What specific home adaptations are covered under CHC?

A. Home adaptations are physical adaptations to the private residence of the participant to ensure the health, welfare and safety of the participant and enable the participant to function with greater independence in the home. Home adaptations consist of installation, repair, maintenance, permits, necessary inspections, and extended warranties for the adaptations. Exhibit A(1) of the CHC Agreement provides more information including a list of covered adaptations. Home adaptations must be specified in the participant’s Person-Centered Service Plan (PCSP) and determined necessary in accordance with the participant’s assessment.
Q11. What types of assistive technology will be covered under CHC?

A. Assistive Technology service is an item, piece of equipment or product system — whether acquired commercially, modified or customized – that is needed by the participant to increase, maintain or improve a participant’s functioning in communication, self-help, self-direction, life-supports or adaptive capabilities. Exhibit A(1) of the CHC Agreement includes a list of covered assistive technology items. Assistive Technology service must be specified in the participant’s Person-Centered Service Plan (PCSP) and determined necessary in accordance with the participant’s assessment.

Q12. Will the CHC-MCO be providing non-medical transportation?

A. CHC-MCOs are required to provide non-medical transportation. Exhibit A(1) of the CHC Agreement provides more information on non-medical transportation under CHC.

Q13. How will CHC-MCOs handle Personal Emergency Response Systems (PERS)?

A. The CHC-MCOs must cover Personal Emergency Response System (PERS). PERS are subject to the continuity-of-care provision, which allows PERS providers to continue as a subcontractor to a service coordination entity.

After the continuity-of-care time period, CHC-MCOs can determine their provider network. Providers must agree to contractual terms and meet CHC-MCO participation requirements. PERS providers who are currently enrolled as a subcontractor to a service coordination entity must enroll as a Medical Assistance provider with the Office of Long-Term Living and contract with CHC-MCOs to provide services to CHC participants.

Q14. What nursing facility supplemental payments are included in the capitated rate and are any remaining in Fee-for-Service (FFS)?

A. Supplemental payments included in the capitation rate include: exceptional durable medical equipment, assessment-related allowable cost for nonpublic nursing facilities (Appendix 4), Quarterly supplemental payments for nonpublic NFs (Appendix 4), County MDOI (Appendix 4), County Quality and Access to Care Payments (Appendix 4), Disproportionate Share Incentive, Supplemental Ventilator Care and Tracheostomy Care.

Supplemental payments remaining in fee-for-service include: Health Care-associated Infection (HAI) and any legislative adds, such as nonpublic Medical Assistance Day One Incentive (MDOI).
Q15. What is CHC's impact on Third Party Liability (TPL)?

A. Under CHC, the Medical Assistance program will continue to remain the payer of last resort. All forms of third party medical coverage (TPL) must be exhausted before CHC-MCOs will pay for a covered service or item. Providers remain responsible to check the Eligibility Verification System (EVS) at the time of service. Providers should ask participants to present, at minimum, their ACCESS card and CHC-MCO insurance card.

Providers will bill the participant’s CHC-MCO for services provided. If the participant has a TPL, including Medicare, providers must bill the TPL first for payment of eligible services and obtain an Explanation of Benefits (EOB) from the primary insurer. Once the TPL has paid or denied the claim, providers may bill the CHC-MCOs for the remainder of the claim.

Providers may not balance-bill participants when Medicaid, Medicare, or another form of TPL does not cover the entire billed amount for a service delivered.

Q16. Will health and wellness education be available under CHC?

A. The CHC-MCO must provide health and wellness opportunities for participants, such as providing classes, support groups, and workshops; disseminating educational materials and resources; and providing website, email, or mobile application communications. Topics to be addressed will include but not be limited to heart attack and stroke prevention, asthma, living with chronic conditions, back care, stress management, healthy eating and weight management, oral hygiene, and osteoporosis. The CHC-MCO may also include annual or other preventive care reminders and caregiver resources. The Department of Human Services encourages CHC-MCOs to identify regional community health education opportunities, improve outreach and communication with Participants and community-based organizations, and actively promote healthy lifestyles as well as disease prevention and health promotion.

Q17. For Continuing Care Retirement Communities (CCRC), can home and community-based services be provided in personal care and independent living settings?

A. Home and Community-Based Services (HCBS) can be provided in independent living settings of CCRCs provided that the CCRC contract and fees paid by the participant do not cover HCBS services.

Current residents of personal care homes (PCHs) who are receiving HCBS may continue to receive services in that setting. Nursing facility ineligible (NFI) duals participants, who are living in PCHs, can also remain in their PCHs and receive physical health services under CHC. Once they need long-term services and supports, these participants must transition to another living arrangement to receive HCBS, unless they are receiving residential habilitation services in a 42 C.F.R. § 441.301 compliant setting.
Q18. Will CHC services be limited?


Q19. Aside from state mandated services, are CHC-MCO’s permitted to offer expanded/value added services?

A. **Revised January 26, 2018** – As permitted by Section V.A.4 of the CHC Agreement, Expanded Services and Value-Added Services, the CHC-MCO may offer participants expanded or value-added services. If offered, the CHC-MCO may feature such services in approved outreach materials. Adding or changing value-added services requires modification of written materials and is subject to approval from the Department.

For more information, please review the CHC Health Plan comparison chart found on the CHC website: [http://www.healthchoices.pa.gov/info/resources/publications/community/index.htm](http://www.healthchoices.pa.gov/info/resources/publications/community/index.htm)

Q20. Are there any requirements in CHC for participant self-directed family/caregiver worker education?

A. The Financial Management Services (FMS) vendor is responsible for direct care worker (DCW) training. The FMS vendor must receive prior approval from the Office of Long-Term of the content of DCW pre-service orientation. Pre-service orientation must, at a minimum, cover the following topics: operational procedures and paper work, roles and responsibilities in independent living system, workplace safety, transparency and fraud, eligibility for public benefits, and worker rights and responsibilities.

The FMS vendor must provide DCW pre-service orientation that provides a basic understanding of the functions and requirements of the participant directed programs, including the role and responsibility of the participants as the employer to direct, supervise, train and select the DCW.

The FMS vendor must have experience in supporting the training and orientation of home caregivers such as DCWs, in labor management training partnerships, and in the development of relevant orientation curriculum and have statewide capacity to implement a consistent, timely preservice orientation program. The FMS Vendor may use a subcontractor to satisfy the pre-service orientation experience requirements.