Community HealthChoices Ombudsmen Questions

1. If a participant has a question that the IEB is unable to answer, is there any other resource or phone number they can call? Apprise is unable to assist with CHC questions and is being told to direct participants to the IEB. The PA Statewide Customer Service Center states they are unable to help, and directs individuals to call the IEB, as does the PA DHS Helpline. Is there anyone at DHS or OLTL who would be able to assist with answering more complicated questions and handling complaints?
   Response: *The CHC Participant Call Center, 1-833-735-4416 was the number provided to participants in the pre-transition flyer. The purpose of this call center was to provide general information about CHC and to assist participants register for the participant sessions.*

   The IEB, 1-844-824-3655, is the entity participants should be calling with questions regarding enrollment packet, questions on the MCOs provider network and participating providers, checking their status of enrollment, and making changes to their MCO selection. The IEB will refer participants to APPRISE for assistance if they have specific questions about their Medicare benefits.

   The OLTL Participant HelpLine, 1-800-757-5042, should be used by current OLTL waiver participants to voice a complaint with their current services, or have questions about the CommCare to Independence Waiver transitions and the OBRA Waiver reassessments and OBRA to CHC transition.

2. There seems to be pressure on the MCOs to reduce rates paid to providers, including PAS agencies. Everyone, but particularly Southwestern PA, is already experiencing a shortage of PAS workers. One reason is that these workers are given many responsibilities for low pay and irregular hours. The lack of PAS workers is already affecting quality of care and even the amount of care available for participants in the area. What is the role of PA DHS in reversing this trend?
   Response: *The Department of Human Services (DHS) is requiring an extended continuity-of-care provision for personal assistance and nursing facility services to promote quality of care and quality of life for participants. The CHC-MCOs must develop a rate configuration that assures that the extended continuity of care period condition will be met and that assures access, quality of life and quality of care.*

3. If an individual is admitted to a nursing facility under private insurance or Medicare, they often will become eligible for Medicaid later in their stay. If a nursing facility only contracts with one MCO, when it comes time for an individual to apply for Medicaid and select an MCO, would they need to select that MCO in order to remain in that facility? If an individual decides to transfer facilities because they want to select an MCO that the facility does not contract with, who is responsible under Medicaid for reimbursement to the current facility while the individual is waiting to transfer?
   Response: *If an individual is living in a nursing facility and enrolled in CHC on January 1, 2018, the individual will be able to stay in that nursing facility as long as they need nursing home services. The individual can also move to another nursing facility in the MCO's network or contact an Enrollment Specialist at 1-844-824-3655 to learn about other CHC plans and the nursing facilities in their network.*

   If the individual is living in a nursing facility and enrolled in CHC after January 1, 2018, the individual must go to a nursing facility in the MCO's network, or ask the MCO to approve their stay in an out-of-network nursing facility. The individual can also contact an Enrollment Specialist at 1-844-824-3655 to learn about other CHC plans and the nursing facilities in their network.

If the individual was not living in a nursing facility when first enrolled in CHC, but now needs nursing facility services, the individual must go to a nursing home in the MCO's network. The individual can also contact an Enrollment Specialist to learn about other CHC plans and the nursing facilities in their network.

4. Appeals for CHC are going to be handled by the Bureau of Hearings and Appeals, including appeals of service decisions. Is an MCO required to provide a participant with a written notice in the event of a service reduction or denial? If so, is this notice required to provide information on how to appeal the decision, including contact information for the Bureau of Hearings and Appeals?
   Response: *A participant must first file a complaint or grievance with the CHC MCO before they can request a state fair hearing. If a CHC MCO reduces or denies services, they will send a notice of reduction or denial to the participant with information on how to file a complaint or grievance with the MCO. At the conclusion of the complaint/grievance process, the MCO will send a notice of decision to the participant, with information on how the participant can request a state fair hearing (appeal). Participants will send their requests for a state fair hearing to the Office of Long-Term Living who will then forward the request to the Bureau of Hearings and Appeals. The Bureau of Hearings and Appeals presented information on this topic at the October 19, 2017 Third Thursday Webinar:*
   http://www.healthchoices.pa.gov/cs/groups/webcontent/documents/document/c_266544.pdf

5. Are the rates paid to nursing facilities under the MCOs going to remain the same as the current Medicaid rates? If not, is a nursing facility that contracts with multiple MCOs permitted to encourage a resident to select the MCO that pays the highest rate?
   Response: *For each CHC phase, the Department of Human Services expects the CHC-MCOs to reimburse nursing facilities at the facility level as the average of each nursing facility's per diem rates in effect for the four quarters prior to implementation; supplemental payments are not part of this calculation. Nursing Facilities may not encourage residents to select the MCO that pays the highest rate.*

6. Are there legal protections for participants who have a D-SNP that contracts with a provider that does not contract with participant's selected MCO, so that the participant does not end up with an out-of-pocket cost they should not receive based on general Medicaid eligibility/status?
   Response: *CHC-MCOs are required to develop and implement Person-Centered Service Plans (PCSP) that address how the participant's physical, cognitive and behavioral health needs will be managed, including how Medicare coverage (if the participant is dual eligible) will be coordinated and how the participant's long-term services and supports will be coordinated. CHC-MCOs will be required to train providers on Medicare coordination for dual eligible services.*

   The CHC-MCO, its subcontractors and Providers are prohibited from balance billing Participants for Medicare deductibles or coinsurance. The CHC-MCO must provide a Dual Eligible Participant access to Medicare products and services from the Medicare Provider of his or her choice. The CHC-MCO is responsible to pay any Medicare coinsurance and deductible amount, whether or not the Medicare Provider is included in the CHC-MCO's Provider Network and whether or not the Medicare Provider has complied with the Prior Authorization requirements of the CHC-MCO.

DHS recently received guidance from CMS that editing for ordering, referring and prescribing (ORP) network providers must be in place for January 1, 2018. MCOs must deny claims for any network providers that orders, refers or prescribes services on January 1, 2018.
If a non-network provider that is not enrolled sets an edit in the MCO claims system for ORP on Jan. 1st, the claim can be paid; however the MCO must:

- *Identify the claims volume for those non-network non-enrolled providers*
- *If the non-network provider has a high volume of claims, work with the provider to have them enroll in MA and credentialed with the MCO*
- *If the provider refuses to enroll in MA and become a provider in the MCO's network, the MCO must work with the member to coordinate care to be provided by a network provider.*

7. Is the consumer-directed direct care worker program definitively (beyond 6 months) going to be preserved by all MCOs? In the community presentation, the presenters suggested this option was not going away, then in later Q&A seemed to double-back and suggest it might after 6 months.
Response: *Both models of participant-direction – employer and budget authority – will continue to available to CHC waiver participants after the 180-day continuity of care period.*

8. What are the details on how the "option to work benefit" is introduced to consumers? For example, can it be made a requirement for receiving part of coverage, or are the consumers going to be receiving pressure from the MCOs to participate in the "Living at home and returning to work" option?
Response: *There is not a work requirement in CHC. As part of the Person-Centered Planning Process, the CHC-MCO will provide information about services available through OVR or similar resources to participants who are not working but express an interest in work or who are working but whose employment status may be jeopardized due to their disability, and will refer the participant to OVR or other resources, unless the participant makes an informed choice not to be referred for this support.*

9. It is our understanding that behavioral health plans are carved out of the whole CHC initiative. However, on slide #36 of the CHC Participant Information Presentation, it says that Behavioral Health Services will be a new benefit for people living in nursing facilities. Does this mean MCOs will be requiring more behavioral health/mental health services from contracted SNFs?
Response: *All CHC participants will be covered by BH managed care through the existing behavioral health managed care organizations (BH-MCOs).*

Behavioral health (BH) services for NF residents is not new; receiving BH services through a BH-MCO will be new for NF residents. 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.

10. Will we have any reporting responsibilities with the MCO's on their consumers/residents in facilities for open cases?
    Response: *This is an ombudsmen issue and should be referred to the Pennsylvania Department of Aging.*

11. Will the MCO's have their own care managers or similar type staff assigned to each consumer/resident in a facility to also handle any issues that we normally provide in Ombudsmen services?
    Response: *The MCOs will assign a service coordinator to all individuals receiving long-term services and supports in nursing facilities or their homes and communities. These individuals will not be expected to handle the types of issues normally address by the LTC ombudsman. However, each MCO will have an internal grievance process for handling individual grievances from participants.*

12. If the MCO does not contract with the facility, will our residents need to relocate to another LTC facility, or will the resident be grandfathered in?
    Response: *CHC participants who reside in a nursing facility when CHC is implemented in the CHC zone will be permitted to continue receiving care at that facility until the participant either leaves the facility or is disenrolled from CHC, or the facility is no longer enrolled as a provider in the MA program. Participants admitted to a nursing facility after the CHC implementation date will receive the standard 60-day continuity of care protections.*

13. If they are grandfathered in, but then admitted to a hospital, can the resident still go back to a facility if the MCO doesn't contract with?
    Response: *CHC-MCOs are responsible for payment of medically necessary nursing facility 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 nursing facility or resides in a nursing facility at the time of enrollment. As long as the participant remains a resident of the nursing facility, a temporary hospitalization will not interfere with or terminate the continuity of care period even if it exceeds the 15-day bed hold period.*

14. Will the MCO's be holding informational sessions at facilities for residents and families?
    Response: *No, per the MCO agreement with DHS, the MCOs are prohibited from engaging in outreach activities at nursing facilities. OLTL has developed a training specific to nursing facilities on CHC so that facilities can assist residents and their family members on CHC. Please see the training at the following link:*
    http://services.dpw.state.pa.us/chccd20171025/presentation_flash.html?_ga=2.130970767.1230603746.1511113098-619277713.1472072104

15. When are the MCOs picking the facilities they will contract with in CHC?
    Response: *MCOs are currently in the process of contracting with nursing facilities.*

16. Is the FED tool finalized and when will it take effect?
    Response: *No, the Functional Eligibility Determination (FED) has not yet been finalized. OLTL is currently targeting March 2018 as the timeframe for implementation.*

17. What will the process be for facilities to request assessments? I heard they will all go through Aging Well before getting to the AAA. Will this slow down the assessment process?
Response: *At some point in the future, requests for level of care assessments will need to go through Aging Well, who will make the referral to one of their local community partners. The Aging Well Statement of Work contains specific timeframes for the completion of assessments.*

18. When will the NH residents be notified of CHC and be able to pick their plans?
Response: *In July 2017, DHS sent informational flyers to potential CHC participants in the CHC phase 1 southwest 14 counties. DHS sent pre-transition notices to these individuals in late September 2017. During the pre-transition period, participants were able to choose the MCO that they feel best meets their needs. If a participant does not choose a CHC-MCO by November 13, 2017, the participant will be assigned to a CHC-MCO by the automatic assignment process described in the Department of Human Services' Client Information System (CIS). Participants who are assigned to a CHC-MCO by the IEB or through the CIS auto-assignment process may select a different CHC-MCO at any time. The IEB will assist participants in choosing and transferring to a different CHC-MCO.*

19. Will personal care residents be affected at all by CHC?
Response: *Yes. Individuals residing in Personal Care Homes who are dually eligible for Medicare and Medicaid will be required to enroll in CHC.*

20. Do the residents get to continue to stay with the same doctors or does that depend on what provider they choose?
Response: *Participants who are dually eligible for Medicare and Medicaid should be able to stay with their current doctors. However, in order for their doctor to refer them for nursing facility or other types of Medicaid services, their doctors will be required to be enrolled as a Medicaid provider.*

21. Will co-pays stay the same?
Response: *CHC-MCOs may not charge a copayment in excess of what exists currently in the MA FFS program. Copayments for services by MCOs are listed on the chart at the following link: https://www.enrollchc.com/sites/default/files/Documents/PA_CHC_PlanCompChart-LTSS_ENG_v18WEB_100817.pdf*

22. If the provider isn't working out for them do, they have the option to choose another within a certain time frame?
Response: *Participants may select a different provider within the CHC-MCOs network at any time, even during the continuity of care period.*

23. Will this affect their prescription coverages?
Response: *Different variables will determine whether there is any effect on participants' prescriptions. These variables include whether the individual is dually eligible for Medicare and Medicaid, whether the individual receives assistance through the Department of Aging's PACE program or whether the individual only receives Medicaid benefits.*

24. Will this affect their long-term stays?
Response: *No.*

25. Are the NH's and PCH's required to help residents on MA pick their choice of the CHC insurance co?
Response: *Nursing facilities and Personal Care Homes should not be choosing an MCO for their residents. If the resident is unable to choose an MCO on their own, the resident's responsible party should be choosing the MCO that is in the best interest of the participant. If the resident has no Guardian, POA or family member to assist them, the resident will be auto enrolled into a CHC plan.*

26. Do they have to have documentation they are offering choice?
Response: *OLTL is not requiring nursing facilities or personal care homes to document choice was provided to the resident. Choice counseling is the responsibility of the IEB.*

27. If resident is confused are they required to work with the responsible party for the choice or are the NH's going to be allowed to pick who they want?
Response: *Nursing facilities should not be choosing an MCO for their residents. If the resident is unable to choose an MCO on their own, the resident's responsible party should be choosing the MCO that is in the best interest of the participant. If the resident has no Guardian, POA or family member to assist them, the resident will be auto enrolled into a CHC plan.*

28. Are all the NH's and PCH's going to be let to auto enroll?
Response: *OLTL is unclear of the meaning of this question; please clarify.*

29. We have one NH who has tricked residents and families into dropping their insurance for straight Medicare and then when they went home they ran into problems trying to figure out to get back what they had. What is in place to prevent things like this from happening related to CHC?
Response: *There are a number of protections in place to monitor the resident's enrollment into a CHC plan. OLTL will monitor the enrollments to determine if a NF is having all of their residents enroll in one plan. The Ombudsman should have a role in monitoring this also. Residents and families still have an opportunity to file complaints both with DOH or OLTL.*

30. Will PA Ombudsman be provided names and numbers of contacts and such to use during complaint investigations we will receive from residents as we investigate and try to resolve/assist residents?
Response: *This is an ombudsmen issue and should be referred to the Pennsylvania Department of Aging.*

31. What does OLTL expect the impact on NH and PCH residents to be after the first 6 months where the insurance companies have to keep the same providers?
Response: *OLTL is unclear of the meaning of this question; please clarify.*

32. Have the NHs and PCH providers/staff received training and info related to their population?
Response: *OLTL has developed a number of trainings for providers, including service coordinators and nursing facilities. In addition, OLTL has reached out to the Bureau of Human Services Licensing to identify the best way to educate and train Personal Care Homes.*

33. What if a resident must go to another hospital for surgery? How will the provider know if that hospital is a participant of the resident's CHC plan? Is it the responsibility of the provider?
Response: *All nursing facility residents will have a service coordinator, who will coordinate necessary physical health services.*

34. Has the CHC eliminated behavioral health services in Personal Care Homes? Will a psychiatrist or physician's assistant still be able to visit a resident in a PCH?
Response: *CHC will not affect services currently being delivered to individuals enrolled in Behavioral HealthChoices. If a person living in a personal care home is receiving visits from a psychiatrist or physician's assistant, this will not change because of CHC.*

35. Will residents have someone assist them with choosing a CHC-MCO?
Response: *The IEB is responsible for assisting participants choose an MCO, and if necessary, transfer to a different MCO.*

36. If a resident does not like the current MCO, can he/she change or is there an enrollment period?
Response: *Participants may select a different CHC-MCO at any time. The IEB will assist participants in choosing and transferring to a different CHC-MCO.*

37. Is transportation covered to medical appointments?
Response: *Yes, non-emergency medical transportation is a covered service for NF residents under CHC and NFs will continue to coordinate the service for their residents.*

38. Will the Pennsylvania LTC Ombudsman Program, and in turn local state-wide Ombudsman responsibilities expand to include Community Health Choices?
Response: *This is an ombudsmen issue and should be referred to the Pennsylvania Department of Aging.*

39. Over time, there have been significant state-wide concerns about the performance of the IEB/Maximus. Is there a mechanism for consumers to complain or grieve if those consumers do not receive good comprehensive and timely information from the IEB?
Response: *Yes. Participants who do not receive good, comprehensive, and timely information from the IEB should call the OLTL Participant helpline at 1-800-757-5042.*

40. Does each MCO have its own provider network of nursing facilities, or will all licensed nursing facilities be included under the three MCO's?
Response: *Each MCO will have their own provider networks, which includes nursing facilities.*

41. What is the specific role of the Ombudsman in assisting residents/consumers with the transition to Community Health Choices?
Response: *This is an ombudsmen issue and should be referred to the Pennsylvania Department of Aging.*

42. What is the mechanism for CHC consumers to complain or grieve if services to those individuals are denied, reduced or terminated?
Response: *Each MCO is required to an internal grievance process for hearing participants' complaints and grievances. Participants must utilize this internal grievance process before requesting a hearing with the Bureau of Hearings and Appeals.*

Additional Questions Received During 11/20/2017 Webinar

Q1: If a participant receives a service denial notice, will appeal rights specifically be included in that notice? The BHA presentation and the CHC materials are unclear on that.

A. Please see the response to Q#4 above.

Q2: If a participant exceeds the 15-day bed hold, will they still be entitled to the first available MA bed?

A. Yes, the CHC-MCOs are required to adhere to 55 Pa. Code § 1187.104(b)(1)(iv) and 1189.103(b)(1)(v) (relating to limitations on payment for reserved beds). If the resident's hospital stay exceeds 15 consecutive days, the nursing facility shall readmit the resident to the nursing facility upon the first availability of a bed in the nursing facility if, at the time of readmission, the resident requires the services provided by the nursing facility.

Q3: Who can a participant call with a complaint or problem with the IEB? Who is responsible for oversight at the state level? Is there a point of contact for participants?

A. Please see the response to Q#39 above.

Q4: In the event of a service reduction, denial, or termination, will the MCO be required to notify a participant in writing of their right to appeal to BHA?

A. Please see the response to Q#4 above.

Q5: Are the behavioral health services for nursing facility residents in addition to the behavioral health services the nursing facility is already required to provide?

A. Please see the response to Q#9 above.