

Call Center

1. What are the call center hours?

Provider services operate normal business hour, 8AM to 5PM. PHW will have emergency/after hours coverage where providers will be able to get a hold of someone 24/7.

2. What happens if participants need something on a Saturday?

After hours coverage will be handled through the PHW call center. Significant issues will be escalated and routed to on-call supervisors.

Claims & Authorizations

1. When will authorizations be sent out for 1/1/18?

The participant selection period ends Monday 11/13/17. PHW will have a good idea of our participants by 11/20/17, but will not have a full list until about 12/20/17. This will be a quick turnaround time, but PHW wants to give you the authorization information once and avoid confusion or lost information.

2. Will there be changes to authorizations and care plans on 1/1/18?

No, PHW will honor the existing care plans and authorizations.

3. Will PHW be flexible with authorizations? The current process has a lot of restrictions.

Our goal is for participants to get services and providers to be paid. The tool for that is the authorization.

4. What's authorized for Nursing Homes?

- a. **Custodial Care:** No authorization
- b. **Skilled:** Continues as it is today

5. How often will providers be sending authorizations?

For Home and Community-Based Services: Authorizations come out when the Care Plan is developed. As the Care Plan is updated, authorizations will be sent. These will be typically good for 1 year.

6. How fast will providers be able to get an authorization for a temporary increase in hours?

If the increase is urgent, PHW will authorize within 24 hours.

7. Will authorizations need Supervisor approval, or can the Service Coordinator make decision?

Service Coordinators have an approval threshold; Supervisors have a higher threshold of approvals; Managers have the highest level. Only the PHW Medical Director can do a denial. Any services above the Service Coordinator's threshold must go to Utilization Management review.

8. Will request for new services require new Assessment/interRAI completed?

Any change in status/condition must be documented in the interRAI to document the new gap in care/need of service.

9. Are annual authorizations tied to calendar years or the Care Plan?

Authorizations are tied to the Care Plan.

10. Will consumer hours be reduced?

Consumer hours will not be reduced during the Continuity of Care (COC) period. After COC, PHW will assess Care Plans to determine if current service hours are appropriate. In most cases, PHW does not believe a reduction would be typical.

11. What about an increase in hours?

Increases and decreases are based on demonstrated need and service gaps. That determination is made by the Service Coordinator in conjunction with the participant.

12. What will be expected of the nursing home to ensure PHW are collaborating appropriately with the MCO?

PHW expects facilities to provide contact names from the NF whom our Service Coordinators should be working with and begin building a collaborative relationship.

13. What do providers do with patients that need to get to a dialysis appointment (or some other outside/specialty service) on 1/1/18 or 1/2/18?

Care Plans should list current transportation needs/arrangements. It will be possible to use the same company. PHW is striving for no disruption to participants.

14. Is overtime authorized for personal care?

- a. **Agency:** Generally, no. However, if there is a special case, PHW will work with you to get it prior authorized.
- b. **Consumer Directed:** If personal care overtime is part of existing care plan, PHW will pay, but will be working diligently to find a solution.

15. How often will authorizations be reviewed & re-authorized?

For Home and Community-Based Services, the goal is “annual” authorizations of service. For 1/1/18, PHW will continue current authorization, then when the next assessment and Person-Centered Service Plan is reviewed, the authorization will be valid for will be for 1 year, unless there is a change in level of care.

16. If an increase in authorization needs to be requested, do you call the Service Coordinator or Program Coordinator?

For any authorization requests, please contact the PHW Program Coordinators at 1-844-626-6813.

17. Will the resident who is in Long Term Care need prior authorization for doctor appointments? I.e. Podiatry, audiology, dental, optometry? When will the resident require prior authorization? How often will updates and authorization occur, if the resident is not receiving skilled care?

Authorizations are not required for non-skilled (Custodial) nursing facility room and board days unless the facility is approved for an additional per diem increase for vent/trach participants and the participant is receiving vent/trach care. Normal physician appointments do not require authorization.

The only other services besides vent/trach per diem that require authorization for nursing facility participants are:

- Daily Vent Care/Supplies
- Exceptional DME

18. When a resident is categorized as needing skilled care under the MCO, how many skilled days will they be allowed, what is the criteria for authorizing skilled benefit is it the same as Medicare guidelines). When ending skilled coverage, do they receive a 48 hour notification prior to end of coverage?

All traditional Medicare rules apply. When participant is Medicare primary, Medicare would still be responsible for days 1-100. If the participant has the PHW Allwell plan, authorization for the skilled stay will need to be obtained through Allwell and claims for the skilled stay will be billed to Allwell. Claims for coinsurance amounts will automatically crossover to PHW for secondary payment if any is due.

19. When discharging to the community, will the discharge coordinator need to get any type of authorization for Home health or medical equipment from the Service Coordinator?

When participants are being discharged to the community the Service Coordinator will work with the facility to ensure that all services and authorizations are in place to ensure a safe and seamless transition to the community.

20. ARQ doesn't exempt any chiropractic visits from authorization requirements. PHW is currently showing all chiropractic visits as requiring authorization. What is the direction?

All Chiropractic visits currently require authorization.

21. Does PHW limit Obstetrics (OB) ultrasounds?

There is no limit in place for OB ultrasounds.

22. How will other medical expenses (OMEs) be handled (ie. dental, audiology, glasses, etc.)?

Services for Participants that are covered benefits should always be arranged for and/or provided by providers that are both participating with PHW and registered to provide services by the state of PA whenever possible. This allows all possible claims expenses to be accurately billed, paid, and encountered with the Commonwealth on behalf of the participant.

With that being said, PHW understands that there will be some situations/expenses that will fall within the category of "Other Medical Expenses" that will need to be reported/expensed on the claim. These should be reported with the same value codes as traditionally billed to the state, and documentation should be retained for audit purposes.

23. How do providers file claims and what is turnaround time for payments?

Electronically through our provider portal, or through HHAExchange. PHW strives to pay providers as quickly as possible on all clean claims.

24. How quickly will authorizations be approved?

Authorizations varies by type, but can be as quickly as 24 business hours.

25. What information is required for authorizations?

Please refer to the PHW provider handbook for required information for authorizations.

26. Will PHW call in authorization or will it all be via a website?

Electronically through our provider portal, or through HHAExchange.

27. Will PHW expect a per unit billing system or will you be working with a PMPM?

Per unit.

28. How does PHW handle the caregiver stipend?

With regard to Nursing Home Transition, many providers have expressed concern over the abuse of nursing home transition funds by family members and caregivers. PHW does not directly pay any funds to family members or caregivers for participants transitioning out of nursing facilities. Nursing Facility transition funds are used to secure items or services needed to ensure a safe transition to the community. Any security deposits, purchases, etc. are paid directly to the vendors, not to family members, participants, or caregivers.

29. How will you guarantee timely payment of claims?

PHW has multiple electronic claims submission options in place to enable easy claims submission, as well as the ability to check claims status and correct claims on our secure provider portal. These, and many other efficiencies, allow for faster payment turnaround times and higher auto-adjudication rates. Additionally, providers utilizing HHAExchange for Electronic Visit Verification (EVV) will have added claims pre-edits that flag for potential billing issues prior to submission to significantly reduce denials and rejects.

30. Will there be additional web-based trainings on specific issues such as claims and the web portal be conducted?

Yes, once contracted, initial provider orientations will be scheduled. Please be advised that HHAExchange trainings are scheduled for EVV providers in December and additional trainings and webinars will be forthcoming.

31. Currently nursing home residents are not responsible for co-pays, will that continue?

Participants in a Nursing Facility setting are Exempt from copays.

32. What happens if inclement weather impacts service delivery? Will you still pay if the service is delivered at a later time/date?

If services are authorized and delivered, services will be paid. PHW understands that situations such as inclement weather may delay service delivery from time to time.

33. How often can PHW bill through your Claim Wizard?

Billing frequency will depend on the service. Nursing Facility services have to be billed monthly.

34. Is it OK to bill 1/1/18 through 1/31/18 with hours?

Billing for the first month post-implementation should be broken out on the claim.

35. SCEs currently bill allotted amount – will they need to itemize?

SCEs will need to submit itemized billing- per member, per day.

36. Will PHW still bill through PROMISE?

No. Providers will need to bill PHW through its web portal, HHAX, or by submitting a paper claim.

37. Please provide clarification on mileage reimbursement

Non-medical transportation, including mileage reimbursement is a covered benefit when included in the person centered service plan (PCSP). Non-Medical Transportation services include mileage reimbursement for drivers and others to transport a Participant and/or the purchase of tickets or tokens to secure transportation for a Participant. Non-Medical Transportation must be billed per one-way trip or billed per item (e.g., a monthly bus pass). Transportation services must be tied to a specific objective identified on the PCSP.

Non-medical Transportation services may only be authorized on the PCSP after an individualized determination that the method is the most cost-effective manner to provide needed transportation services to the Participant and that all other non-Medicaid sources of transportation which can provide this service without charge (such as family, neighbors, friends, community agencies) have been exhausted.

Non-Medical Transportation does not cover reimbursement to the Participant or another individual when driving the Participant's vehicle.

38. Does PHW allow billing for same-day service?

PHW's claims system will accept claims for same date of service, however the claims system will reject any future dated claims.

39. Is a Participant number needed to submit a claim?

No. Providers can submit claims using the participant's Medicaid ID number.

40. Question on time of services rendered. Will PHW still pay if outside of that time?

Yes. PHW will pay for services delivered, as long as service is delivered.

41. Will PHW conduct Claims Audits?

Yes. PHW will conduct periodic claims audits. PHW recommends that providers keep all documentation for Other Medical Expenses (OMEs).

42. Is a Medicare denial needed if services are not covered by Medicare?

In order for Medicaid to pay, it will be necessary to have a Medicare denial on file.

43. Does PHW need to notify anyone that the Participant enrolled with you for crossover claims?

No notification is needed in order for claims to crossover to PHW. If the participant is FFS Medicare, the claim and primary Explanation of Benefits (EOB) will automatically cross over via our Coordination of Benefits Agreement.

If the participant has a DSNP plan through any carrier other than PHW's Allwell plan and any portion of the claim was paid by the DSNP, a copy of the DSNP EOB will be required in order to process the claim for secondary payment.

44. What is an EDI Trading Partner?

EDI stands for Electronic Data Interchange, and our EDI trading partners are the entities that enable electronic claims transmissions from our providers.

Complaints & Grievances/Critical Incidents

1. Providers have 24 hours to report Critical Incidents (CIs). How do you want us to report? Through EIM? Call you? Who is required to close it?

Providers who currently have a process in place for reporting may continue their process. Providers who do not have a process will be able to report using the Plan's Hotline 1-866-535-2545, or by faxing the information to 1-844 873-7451.

PHW will contact the service coordinator and/or the facility and assist with ensuring proper notices have been provided, any investigation needs and closing the critical incident at the conclusion.

2. Is PHW staffed to take all the calls for Critical Incidents?

Yes. PHW has qualified staff to receive and process critical incident reports.

3. Who will be reviewing Critical Incidents? RNs? Medical Staff? Non-medical staff?

The type of PHW staff who will review a critical incident report depends upon type of critical incident (for example – medical vs financial).

4. Why is a “normal” hospitalization reported as a Critical Incident? For Critical Incidents, what is the definition of Hospitalization?

Critical incident reporting guidelines are dictated by the Commonwealth. Please refer to the commonwealth guidelines:

[Home and Community-Based Providers Nursing Facilities](#)

5. Are medical providers Critical Incident-required reporters?

Yes.

6. For Critical Incidents, will providers be notified of the result of an investigation?

Yes

7. Who will conduct the Critical Incident investigation? Adult Protective Services? Service Coordinator?

Typically, the PHW Service Coordinator will conduct the investigation. However, if there is a clinical component a nurse will also be involved.

8. What is considered an “unplanned hospitalization,” and how are they reported?

Per DHS guidelines, if participant is admitted for treatment of an existing condition that has become acute, there is no critical incident. However, if a new condition or a routine condition occurs that the participant did not have prior then there would be a critical incident report.

Being admitted for a non-routine medical condition that was not scheduled or planned to occur is a critical incident; a routine hospital visit for lab work or routine treatment of illness of a participant is not a critical incident. A death that is suspicious or of unexplained causes is a critical incident. A death due to natural causes is not a critical incident.

For Nursing Facilities, the reporting of an unplanned hospitalization is consistent with current DOH guidelines.

Contracting/Network

- 1. Will PHW be contracting with facilities that are on provisional licenses? Intergovernmental transfer contract process...how will PHW work with PACAH on disbursement of safety net funds in accordance with Appendix IV? Will your company eliminate PAS agencies after the first 6 months per your discretion?**
PHW will NOT eliminate agencies, and participants will always have a choice of agency.
- 2. Will the billing procedure be the same as PROMISE? Will it take up to 3-4 weeks when you submit a claim to get reimbursed or will it be done in a more-timely manner?**
Reimbursement should be timelier, especially with an electronic clean claim.
- 3. Will PHW and all other entities do audits to see if agencies are in compliance?**
Yes. More information regarding compliance audits will be shared as the program is developed and implemented.
- 4. Outside of agencies being in compliance, what do you expect from Personal Attendant Service (PAS) agencies?**
A complete quality and compliance framework will be provided, however PHW is currently gathering information on the best measures and process to be implemented.
- 5. Will the MCO training sessions be considered mandatory as a condition of being a network provider?**
Yes. Training sessions will afford providers insight into accomplishing your work, meeting SLA's, and ultimately how to bill PHW and be paid for services.
- 6. As soon as a provider signs a contract with an MCO, will that organization be automatically listed on the respective provider directory, which will be used by Maximus?**
Upon receipt of a signed contract and all supporting credentialing documents, providers are credentialed and loaded into PHW system for business. When the credentialing process is finalized and providers are actively enrolled with PHW, they will appear in the Provider Directory.
- 7. What should a provider do to correct its information if it appears incorrectly on the provider directory?**
Providers can reach out to their assigned Provider Network Specialist or call Provider Services 1-844-626-6813 to correct its Provider Directory listing.
- 8. Consumers have been mailed a printed directory. How often will this be updated and redistributed to reflect changes and new providers?**
The Provider Directory is updated weekly and available on the PHW Website for use: www.PAHealthWellness.com
- 9. Are MCOs providing Maximus with an updated provider directory to inform the conversations regarding MCO choice?**
Yes. PHW provides Maximus with regular, weekly updates.

10. Homecare providers have a single office location, but may serve clients in many surrounding counties. Does your provider directory list providers by service area or office location?

The PHW Provider Directory lists providers by service area.

11. If a resident goes to a non-participating provider such as a dentist or needs glasses, will PHW still be able to use the bill as an OME (Other Medical Expense) on the bill?

Services for Participants that are covered benefits should always be arranged for and/or provided by providers that are both participating with PHW and registered to provide services by the state of PA whenever possible. This allows all possible claims expenses to be accurately billed, paid, and encountered with the commonwealth on behalf of the participant.

With that being said, PHW understands that there will be some situations/expenses that will fall within the category of "Other Medical Expenses" that will need to be reported/expensed on the claim. These should be reported with the same value codes as traditionally billed to the state and documentation should be retained for audit purposes.

12. Will Personal Attendant Services (PAS) agency rates be the same?

PAS rates will be paid at the same regional rates currently paid by the state.

13. Transportation is important to get patients to places. How will this be handled?

PHW is contracting with a medical transportation vendor. Transportation will be handled through that vendor.

14. Are you contracting with ambulance companies?

PHW is contracting with a transportation vendor for non-emergency situations. All covered medical and non-medical transportation will be handled through that vendor.

15. Will reimbursement remain the same?

Yes. Please check your contract or call your Provider Network Specialist to assist with review.

16. How long is our contract effective?

Contracts are effective for 3 years.

17. Do the SCEs have to be NCQA accredited to be a contracted provider with PHW?

No.

18. Is there a separate entity for non-medical transportation?

PHW is contracting with a transportation vendor for non-emergency situations. All covered medical and non-medical transportation will be handled through that vendor.

19. Why do you differentiate between a contracted and non-contracted provider?

If you are not contracted, it may delay our ability to pay you, and PHW will not be able to list you in our Provider Directory.

Electronic Visit Verification (EVV)

- 1. Has the state updated the regulations around EVV when it comes to use of cell phones/GPS?**

This has not been finalized yet.

- 2. If we already have EVV, how does that work? If a provider is enrolled with HHAeXchange (HHAX), it sounds like things will be easy. But what happens if a provider chooses to stay with existing EVV vendor? If providers have an existing EVV system, when will they connect with the providers?**

Have you received a survey from HHAeXchange? Once that is filled out and you express that you want to stay with your current EVV vendor, they will send you an information packet. Providers are encouraged to direct questions regarding their specific situations to PAintegration@HHAeXchange.com

- 3. Will EVV be used by SCEs as well?**

PHW is looking into the benefits of EVV being used by SCEs as well, but this is not final yet.

- 4. Will HHAeXchange interface with State Aging Management System (SAMS)?**

No, not yet.

- 5. What is the history of HHAeXchange?**

For more information regarding HHAeXchange, please visit their Website:

<https://hhaexchange.com/>

Home Modifications

- 1. How will you handle home modifications? Will there be a separate meeting to discuss?**

There are no current plans to hold separate meetings. PHW encourages Home Modification companies to contact PHW to discuss ongoing opportunities.

- 2. How will Home Mods work?**

PHW is in the process of finalizing the Home Modifications program. PHW will be notifying interested parties once completed.

Marketing

- 1. When you make updates to the information on your Website, will you list the date of the most recent update?**

Yes.

Medicare

- 1. Is the "Allwell" aligned dual the only Medicare product you offer in PA?**

PHW offers MAPD and D-SNP through AllWell from PA Health & Wellness.

- 2. Is "Allwell" only a product for aligned duals, or will it also be available to Medicare beneficiaries who are not Medicaid eligible?**

PHW offers both MAPD and D-SNP plans through Allwell from PA Health & Wellness.

3. Do you offer another Medicare product that a CHC member w/UPMC or AmeriHealth could potentially be enrolled in?

PHW offers MAPD and D-SNP through Allwell from PA Health & Wellness. Members can enroll without selecting PA Health & Wellness for CHC.

Provider Relations

1. Do you have an online Provider Manual? Is the Provider Manual out yet?

PHW is awaiting approval from the Commonwealth for the Provider Manual. PHW expects to have it posted to our Website within the next week or so.

2. When will you train on the Web Portal?

PHW will be training on the web Portal in December 2017.

3. I want on-site training. How do I arrange that?

Contact your Provider Network Specialist (PNS) or email us at information@PAHealthWellness.com.

4. Why are some physicians showing as not accepting new patients?

If there's a question about the information showing in the directory, you can ask the PNS representative to validate that it's accurate.

5. Account manager for the Web Portal – can you add multiple TINs?

Yes.

6. Suggestion: definition of terms and acronyms – can you share this with providers so PHW can better understand the conversations?

A glossary of terms and acronyms is posted to the PHW Website here.

7. Will the December webinars be repeating or a series?

Webinars will be held on an ongoing basis.

8. Can a pending contractor access these trainings?

Yes, but a provider must be participating to sign up for the Web Portal. If non-participating, providers will be able to sign up after submission of first claim.

9. How long does it take to appear in Find a Provider?

This will depend on how quickly PHW receives all information and if credentialing required. After that, PHW anticipates an approximate turnaround of 2 days.

Service Coordination

1. Retroactive eligibility and timely filing: what happens with claim submission when a member is retroactive?

Per the Commonwealth, there will be no retroactive eligibility with the CHC program. When participants are pending eligibility determinations, upon approval, they will become eligible with CHC the day after approval is received and all retroactivity will be billed to either Fee-for-service or the HealthChoices plan, so timely filing of retroactive period to the CHC plan will not be an issue.

- 2. The County Assistance Offices in each county have a lot of problems getting consumers approved for services in the system. This creates a problem for billing. Have MCOs thought this through?**

PHW is aware of the reported issues and is planning accordingly.

- 3. Please give a step-by-step process for how a Personal Attendant Services agency will receive the first participant in CHC.**

1. Participants individualized needs are identified during the care and service planning process
2. Authorizations are created based services prescribed during the care and service planning process
3. The authorization team would communicate with agencies to confirm agency's ability to provide the service
4. If confirmed the authorization letter would be faxed or emailed to the agency
5. PAS authorizations are also provided to our EVV Vendor and displayed on your agency's specific portal containing all information available on the authorization notification letter.

- 4. How will the care plans be written? Will they be specific?**

We use the person-centered approach to all our care and service plans, meaning each care/service plan would be specific to that participants needs, condition, including ADLS/IADLs and other factors such as natural and care giver supports. This results in a very individualized process, as no two participants needs are the same.

- 5. Are MCOs going to provide the same level of assistance for back-up coverage?**

Yes. All services are required contractually to have a contingency plan if the original formal provider or PDO provider are unable to make a visit. Back-up plans should also take into consideration Emergency, (i.e., fire, unforeseen death of primary caregiver, unforeseen admission to inpatient for the caregiver, etc.) and Disaster, (i.e, inclement weather, acts of nature, wild-fires, etc.

- 6. How will SCEs know which MCO our Participants have chosen? And when?**

1. SC Assignments would be communicated to each agency and available through our portal
2. This communication would occur in December, however this is dependent on the MCO receiving the information from the state.

- 7. How will COC Participants be assigned to Service Coordinators?**

1. All COC participants will maintain their current Service Coordinator unless the participant chooses otherwise.
2. This information would be provided to the MCOs by the State.
3. SC Assignments would be communicated to each agency and available through our portal.

- 8. What is the timing for a consumer to select their plan?**

Participants had until 11/13/17 to select a plan. They are now being auto-assigned. Please note that a participant may change plans at any time.

- 9. Are you planning on extending the COC period?**

No. However, PHW plans to use this period to figure out how to better work with SCEs.

10. When/how will PHW know which MCO the participants chose?

PHW anticipates receiving the preliminary file on 11/20/17 and the final on 12/20/17.

11. If a participant switches MCOs, how will the provider know?

Providers can check eligibility through our portal and can still check state Electronic Verification System (EVV) for eligibility – The EVV will not be going away.

12. What is the effective date for billing MCOs?

Providers can bill the participant's MCO for services rendered on or after 1/1/2018.

13. Can you see future eligibility through the web portal?

No.

14. What is the cut off for participants to change plans?

Participants will need to select by 11/13 or they will be auto-assigned, but participants have the ability to change plans at any time.

15. How are MCOs paid by the state?

PMPM depending on if participant is in NF or home based.

16. How many participants do you plan to capture?

This information has not been made public at this time.

17. Where can Providers get CHC enrollment packets?

Providers can access more information on www.enrollchc.com

18. With this program, do Quality Management Efficiency Team (QMET) audits disappear?

Please refer all QMET audit questions to the commonwealth.

19. Can PHW provide service to members from another state?

CHC is a plan that covers eligible Pennsylvania residents. It does not restrict you from seeing members with coverage other than CHC.

20. Will providers be notified if a Participant changes MCOs?

No. It's important that eligibility is checked frequently.

21. Will PHW use COC period to determine good, better, best Durable Medical Equipment providers? Will you consider value-add services? Are authorizations required for DME?

Yes to all questions related to DME.

22. How will PHW conduct Nursing Home Transition?

PHW is in the process of finalizing the Nursing Home Transition process. It will notify affected providers once that process is complete.

23. How do you plan to run Nursing Home Transition (NHT) with the current NHT providers?

PHW will collaborate with all NHT providers upon transition to determine the active transitions. PHW will hold weekly status reports with current providers to move toward NHT completion. All new NHT's post 1/1/18 will be managed by PHW.

24. Does the free cell phone apply to nursing home residents?

Yes. Although not as commonly utilized in nursing facility settings, if a participant would like to utilize the safelink phone benefit, they are eligible for inclusion in the program.

25. Will repairs to a motorized wheelchair be covered?

Repairs to motorized wheelchairs will be covered when authorized and may fall under the exceptional DME program. The participant's Service Coordinator should be contacted to determine coverage of equipment and/or repairs in that participant's specific situation.

26. How will you case assign in Service Coordination?

COC participants will be assigned to their current Service Coordination Entity (SCE)/Service Coordinator (SC). Specific processes will be tailored to SCE, depending on technical ability/need.

27. What is your expectation on staffing for Service Coordination? 1 SC to 60 cases?

This will vary by member type (Nursing Home, Waiver/Community, Community Wells) and other factors such as driving distance, facility size etc.

28. How many Service Coordinators (SCs) per geographical area (county) do you expect to need?

This will vary by member type (Nursing Home, Waiver/Community, Community Wells) and other factors such as driving distance, facility size etc.

29. Will the SCs be exclusive to your plan?

All PHW Service Coordinators will be exclusive to our plan. However, if an external Service Coordinator is utilized, they may serve multiple plans.

30. When will you be providing training to staff?

Information about training will be posted on the PHW Website and providers will be notified about future training opportunities.

31. Can providers request on-site individual training?

PHW would prefer to do group trainings with opportunities to "Train the Trainer". If you have special needs, PHW will work with you to meet those training needs.

32. What is the ratio for case manager and PAS, Consumer Directed and Nursing Home participants for PA Health and Wellness?

- a. LTC (participants electing domicile in nursing facility) 1:120
- b. HCBS (participants electing domicile in community, including ALF) whether through formal or informal providers) 1:75

33. Please explain how PHW will begin to implement value-based purchasing for PAS agencies. What measures will be used to measure quality?

Person Center Service Plans will be written in accordance with 42 CFR42 C.F.R § 438.208(c)(3) (c), § 441.301(c)(1) through (3) and PHW/Commonwealth Contract.

34. Will my agency be required to have an operating EVV system on January 1 when CHC is implemented?

EVV is not yet a requirement but a recommendation, working with our EVV Vendor streamlines the billing process as it supports the PROMISE-like capabilities the state system provides, but also add some automation.

35. How will the CHC MCO audit my agency? This is now done by Quality Management Efficiency teams.

The care and service plans would all be transferred from the state to the MCOs. PHW plans to prepopulate the service plans into our systems.

36. How will a provider find which MCO their consumer/patient has chosen and when will that information be available and where?

PHW would notify you of any participants that transition to the plan. There are limitations, such as if the data PHW receives does not indicate that a member is currently assigned to a Service Coordination agency.

37. Will the current care plans transfer from the state to the selected MCO?

Yes, the care and service plans would all be transferred from the state to the MCOs, PHW plans to prepopulate the service plans into our systems.

38. How is a provider alerted when there is a change in MCO choice?

If the participant elects to move to another MCO, the terminating MCO will discontinue their authorization with you upon notification by the Commonwealth of the termination. The receiving MCO is supposed to get the current care plan from the terminating MCO for Transition of Care (TCO).

39. Can you provide a step-by-step process for what happens once a participant selects a CHC-MCO?

- a. The commonwealth transmits the participant's demographic information to the respective MCO.
- b. PHW will determine is the participant is, LTC (meaning residing in a nursing facility) or HCBS (meaning living in an Assisted Living Facility (ALF) or private/community domicile. Participants in LTC are assigned to PHW SC.
- c. New HCBS participants are assigned to PHW SC. Transitioning HCBS participants, are assigned to their current respective SCE.

40. Can you provide a similar step-by-step for someone who is auto-enrolled?

- a. The commonwealth transmits the participant's demographic information to the respective MCO.
- b. PHW will determine is the participant is, LTC (meaning residing in a nursing facility) or HCBS (meaning living in an Assisted Living Facility (ALF) or private/community domicile.
- c. Participants in LTC are assigned to PHW SC. New HCBS participants are assigned to PHW SC.

41. If a CHC participant is in need of pill box fills and assistance with a bowel routine, will these tasks be performed by an aide working for a PAS agency or would they be considered skilled and billed to Medicare?

This will depend on the individual participant. If, as in this example, the participant has been receiving pill box fills and/or bowel routine care through the Medicaid waiver services, these services will continue through the PAS agency. If the participant deteriorates and needs different or more acute care services, that MAY temporarily shift to skilled services until the member is stabilized and then will return to PAS agency. It could be only a temporary increase in PAS services until the participant's condition stabilizes and services will then reduce back to pre-exacerbation service levels.

42. What will be the process for an agency to request additional hours based on a participant's change of condition?

The agency's caregiving worker should immediately report to PHW's Program Coordination (PC) unit any changes in condition/trigger events as described in the contract. The PC unit, in turn, will notify the assigned SC. Depending on the urgency of the matter, as ascertained by the SC discussing the issue with the participant/participant's representative the SC will complete telephonic reassessment or in-person reassessment within 24-48 hours. If findings through reassessment determine deterioration of the participant with commensurate increase in care gap, the SC will authorize additional services either through formal providers or community resources. If formal services are offered the participant will select their preferred provider and authorizations will be issued.

43. How will a home health agency that is providing skilled care to a CHC participant be informed that another agency is also providing Personal Attendant Services (PAS)? And how will that care actually be "coordinated?"

If the participant is a dual member, both agencies will not simultaneously be providing PAS. If the Home Health agency is providing skilled services, they will provide PAS until Medicare benefit is exhausted. Then the PAS would be moved to LTSS PAS provider for Medicaid benefit.

If the Home Health agency provides both, they will keep the participant and PHW would insist that formal worker would remain the same for continuity of care of the participant.

If a non-dual/Medicaid only participant, they will receive PAS from LTSS benefits through the Medicaid PAS provider. It will be coordinated by the SCE's SC or PHW SC.

44. How will service coordination entities fit in to CHC, both during and after the continuity of care period?

All currently enrolled participants will remain with their current Service Coordinator, unless the participant requests a change for the continuity of care period. PHW plans to determine if provider agreements will extend past the initial 180 days based upon a case-by-case review. SCE's will need to meet or exceed PHW's SLAs to be considered for continuation. Additionally the SCE will need to be NCQA accredited.

45. Will MCOs require accreditation for non-medical providers?

For the first 180-days NCQA accreditation is not required.

46. What happens to Service Coordination after COC period?

PHW is currently using internal SCs and contracting with SCEs. PHW will use COC period to determine if there will be an ongoing association post-COC. The criteria for continuing the relationship is based on SCE size and meeting launch indicators. For more information on the metrics, contact PHW's Provider Relations.

47. Are external Service Coordinators going to be phased out?

The plan is not to phase out SCEs. The criteria for continuing the relationship is based on SCE size and meeting launch indicators. For more information on the metrics, contact PHW's Provider Relations.

48. Will PHW use the same form for Care Plans or will you have your own?

PHW will send you its form.

49. Will participants have their choice of Service Coordinator?

If participants do not choose a Service Coordinator in the beginning, PHW will use its own until one is selected.

50. Why are you going to keep internal/external Service Coordinators if they are doing the same job?

PHW doesn't know if it's the same job at this point. There may be differences in scope of work. PHW is going to use the COC period to learn more and determine the best path forward.

51. What platform with SCs work on starting in January?

The goal has been to let SCEs continue to use the current systems, but the plans are now required to track Launch Indicators. Nothing is final, but PHW believes the simplest way is to use our Client Portal.

52. Will training include training on interRAI?

SCE training will contain all topics needed to maximize resource appropriation.

53. Will you require SCEs to dedicate staff to your MCO?

No.

54. Will SC be involved with Nursing Facilities?

Yes, as appropriate.

55. Service Coordination and NHT – can they do both?

Yes. Both can co-exist, but the focus will be on Service Coordination.

56. Personal Care Attendant/Respite after COC – Will they need physicians' orders?

No. If they are on Care Plan, PHW will approve them.

57. Are the education requirements changing for current Service Coordinators and Supervisors? Social Work license, etc.?

Each MCO can approach the Commonwealth for exemption/waiver for changes as needed for SC education, licensure and experience contractual obligations.

58. Will new Participants default to receive Service Coordination services by PA Health & Wellness?

All LTC participants and new HCBS participants will be enrolled by a PHW Service Coordinators.

59. Will new Participants be provided with a list of external Service Coordination contracted providers upon intake?

New participants are offered the opportunity to select their preferred service providers.

60. Should contracted Service Coordination providers expect any periods of not receiving new Participant cases? Or the opposite, could Service Coordination providers potentially receive Participant cases at a high rate?

PHW will be assuming all new member intakes and services as of 1/1/18. As the COC period evolves, PHW is looking at performance as an indicator for maintaining relationships beyond the COC period. Please feel free to outreach to PHW for an onsite visit and discussion if you are interested in exploring future opportunities.

61. Will Service Coordinators be allowed to work with other MCO Participants?

Provider-employed service coordinators may work with participants of any MCO. PHW-provided service coordinators will only work with plan participants.

62. Can Service Coordinators work with MCOs & OLTL Participants that are not changing over yet?

Yes

63. Will Service Coordinators still be using HCSIS & SAMS during the Continuity of Care period?

Yes

Technology

1. What do you expect in terms of technology? Will you provide any?

Web-based, Windows, or devices with Internet Explorer 9 (IE9) or above, ability to print and sign or sign on screen. Equipment will not be provided.

2. What will be your software platform for cases (documentation)?

PHW's platform is compatible with internet explorer 9 or above.

3. What will be your software platform for billing?

PHW have various billing tools, preferably through HHAeXchage, Our Provider Portal or Paper.

Miscellaneous

1. In the enrollment packets that residents received there is a list of LTSS items. What items on this list also apply to nursing home residents? For example, assistive technology, financial management services, specialized medical equipment and supplies.

A listing of the LTSS-covered items/services is available via the PHW website under the For Participants section- <https://www.pahealthwellness.com/members/ltss/benefits-services/benefits-overview.html>

