

AN ADVOCATES GUIDE TO COMMUNITY HEALTH CHOICES

Pennsylvania's New Managed Long-
Term Services and Supports
Program

May 2018



Center for Advocacy for the Rights & Interests of the Elderly

An Advocate's Guide to Community HealthChoices: Pennsylvania's New Managed Long-Term Services and Supports Program

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*A project of the Center for Advocacy for the Rights
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Community HealthChoices Advocate Handbook

I. Introduction

In 2018, Pennsylvania started a new Medicaid managed care program called Community HealthChoices (CHC). Pennsylvania already has a mandatory 20-year-old Medicaid managed care program, called HealthChoices, however, HealthChoices does not cover all Medicaid participants. CHC expands Pennsylvania's Medicaid managed care to people who were not in HealthChoices and were receiving Medicaid benefits through the Medicaid Fee-For-Service system. Medicaid recipients in nursing facilities, receiving Waiver services, or who are dually eligible for Medicare and Medicaid are covered by CHC, as of January 1, 2018 in the Southwest zone of the state. CHC begins in the Southeast on January 1, 2019 and in the remainder of the state on January 1, 2020.

It is challenging for consumers to understand the differences and complexities of the Medicaid and Medicare programs. Medicaid is a jointly funded federal and state program administered by the state covering health care and other related benefits such as Medicare out-of-pocket costs, nursing home care, and home and community-based services for certain people with low income and limited assets. Medicare is a federal health program administered by the Centers for Medicare and Medicaid Services (CMS) for eligible people age 65 or older or persons under 65 who qualify based on having a disability.

CHC will provide Medicaid physical health and long-term services and supports to more than 400,000 Pennsylvanians through managed care plans that are under

contract with the state. Because Participants will transition from Medicaid Fee-For-Service to CHC, the shift to managed care represents a significant change in how services are accessed and delivered.

***Advocacy note:** Advocates should be aware of how different Medicaid managed care is from Medicaid Fee-For-Service (as outlined in this handbook) and how likely it is that CHC Participants might not understand all the differences.*

This Community HealthChoices Advocate Handbook was prepared by the Center for Advocacy for the Rights and Interests of the Elderly (CARIE) with the generous support of The Independence Foundation. Its purpose is to provide advocates with a resource for understanding Community HealthChoices and contact information to CARIE and other organizations for when issues or concerns arise. "Advocacy notes" are incorporated to provide tips and signal important details that will be necessary to monitor. An electronic version of this handbook can be found at www.carie.org. The electronic version has embedded links to websites and cited materials.

II. What is Community HealthChoices?

Community HealthChoices (CHC) is a Medicaid managed care program. Through CHC, eligible individuals are provided with Medicaid physical health and long-term services and supports through their choice of three managed care insurance plans that are under contract with Pennsylvania.

Long-term services and supports (LTSS) are home and community-based services or nursing facility services that help people with activities of daily living (bathing, dressing, toileting, feeding/eating, walking, transferring from bed to chair, etc.) and instrumental activities of daily living (paying bills, grocery shopping, etc.).

Many other states have recently moved their LTSS population into managed care as a means of controlling costs. Pennsylvania says this is not the reason driving its efforts but that it created CHC to: "(1) enhance access to and improve coordination of medical care and; (2) create a person-driven, long-term services and support system in which people have choice, control, and access to a full array of quality services that provide independence, health, and quality of life."

The CHC program serves individuals who have Medicare and Medicaid as well as those who only have Medicaid but have long-term service and support needs. Most of these individuals have been getting their Medical Assistance/Medicaid physical health care through the Medical Assistance Fee-For-Service program, using their Access card. This also includes those who receive LTSS through a Home and Community-Based Waiver Services program, like the Aging Waiver or the Attendant Care Waiver, or through a nursing facility.

The Community HealthChoices program is mandatory, meaning that all eligible individuals are put into the program, unless they already participate in the Living Independence for the Elderly (LIFE) program or they are eligible for and select the LIFE program instead of CHC. (The LIFE program is not available in some areas of the state.)

How Does CHC Differ from the Current System?

CHC is different from the Medical Assistance Fee-For-Service system in that consumers are enrolled in a managed care plan through a private insurance company that is charged with coordinating and arranging all of their services. Managed Care Organizations (MCOs) receive one payment per Participant per month. This is called a capitation payment. Each CHC-MCO receives this single payment to cover all items and services provided in a month. If actual costs for items and services in a month are less than the capitation payment amount, the CHC-MCO retains the excess. If actual costs for items and services in a month are more than the capitation payment amount, the CHC-MCO pays that excess out of its pocket. This fixed payment is part of what creates incentives to keep costs low – ideally through better managing care but, potentially also through cuts in services. Overall, managed care differs from the previous Medicaid service system in which LTSS are reimbursed with a fixed fee for each service provided.

***Advocacy note:** Advocates will want to monitor service levels to make sure that services (like personal care hours) are adequate or not reduced from what they had been in an effort to reduce costs.*

Other Managed Care Features as Compared to Fee-For-Service

Since CHC is a managed care program, Participants choose a managed care plan from among those contracting with the state. Once enrolled, Participants must follow the rules of the managed care plan and must use providers that participate in their managed care plan except for some Medicare providers, although there may be overlap. Each of the three CHC-MCOs have different networks.

Additionally, the providers participating in a managed care plan are typically more limited than the network of providers used in a fee-for-service system as consumers in a fee-for-service system can use any Medicaid participating provider.

When does Community HealthChoices Start?

Community HealthChoices began in the Southwest on January 1, 2018. It begins in the Southeast on January 1, 2019 and in the remainder of the state on January 1, 2020.

III. Who is Eligible for Community HealthChoices?

Eligible Individuals

Generally, consumers are eligible for CHC if they are age 21 years of age or older and

receive full Medicare and full Medicaid coverage or:

- 1) Need or already receive Medicaid long-term services and supports through the Attendant Care, Independence, COMMCARE, or Aging waivers;
- 2) Need or already receive Medicaid long-term services and supports through the OBRA waiver AND determined to be Nursing Facility Clinically Eligible (NFCE);
- 3) Receive care in a nursing home paid for by Medicaid.

Excluded Individuals

There are some exceptions to who is eligible. Individuals fitting one of the following criteria are not eligible for CHC.

- 1) People who participate in Act 150 but do not have both full Medicare and full Medicaid. *Act 150 participants that have full Medicare and full Medicaid will be in CHC for physical health coverage only and will still get their LTSS through the Act 150 program.*
- 2) Individuals who have intellectual or developmental disabilities (ID/DD) and are enrolled in services (other than or in addition to supports coordination) through DHS' Office of Developmental Programs. *Individuals who have ID/DD, age 21 or older, and are only receiving supports coordination through ODP are eligible for CHC.*
- 3) Individuals who reside in a state-operated nursing facility, including the state veterans' homes.
- 4) People who participate in the OBRA waiver but have not been found to meet the level of care of Nursing Facility Clinically Eligible (NFCE).

The CHC program is mandatory, meaning that eligible individuals must participate in the program unless they already participate in the Living Independence for the Elderly (LIFE) program or they are eligible for and select the LIFE program instead of CHC.

Individuals Who Participate in OPTIONS or Act 150

Consumers who participate in OPTIONS or Act 150 and have both full Medicare and full Medicaid receive their Medicaid physical healthcare services from the CHC program. These are consumers who are nursing facility ineligible (NFI), i.e., not nursing facility clinically eligible (NFCE), or else would be receive their LTSS through CHC. The nursing facility ineligible participants in OPTIONS and ACT 150 continue, however, to get their long-term services and supports from the OPTIONS or Act 150 program.

How Does One Establish Medicaid Eligibility?

An applicant for Medicaid must apply with the state, through the local County Assistance Office (CAO) or through [the COMPASS portal](#). The state reviews the application to determine if the applicant is financially eligible for Medicaid. This is referred to as the financial eligibility determination.

Applicants for Medicaid LTSS must also undergo a functional eligibility assessment to determine whether they are Nursing Facility Clinically Eligible (NFCE). The state will soon have a new tool for this purpose, the Functional Eligibility Determination (FED). The FED will begin to be used in July 2018.

***Advocacy note:** As the FED is new, we encourage you to call CARIE or local Legal Services with any problems or concerns about its use and results.*

Aging Well, a subsidiary of the Pennsylvania Association of Area Agencies on Aging, completes the FED for LTSS applicants and conducts the annual redeterminations.

***Advocacy note:** Failure to complete the redetermination process will lead to a loss in coverage for Participants, who will need to re-apply to re-establish eligibility.*

IV. How to Join Community HealthChoices

How Does One Enroll in CHC?

All enrollments are processed through the Independent Enrollment Broker (IEB), currently Maximus. The IEB is an entity that is under contract with the state to provide enrollment choice information to potential Participants and enrolled Participants, and to process enrollments into CHC-MCOs. The IEB must follow state rules for providing choice information, processing enrollments, and processing plan change requests.

***Advocacy note:** Advocates should be sure that Participants know that the IEB is required to provide detailed provider network and plan formulary information to help each Participant select the plan that is best for him/her based on their current providers and medications. Contact CARIE with any problems or concerns about enrollment.*

Eligible Individuals Receiving Medicaid at the Start of CHC

Most eligible individuals will be automatically enrolled into a CHC-MCO when CHC starts in their part of the state. Eligible individuals receive multiple written notices about their automatic enrollment. These notices urge eligible individuals to call the IEB to choose a plan. If an eligible individual does not make a choice, they will receive a notice that states which of the three plans the state is proposing for the individual and that offers the individual the opportunity to call and to choose a different plan before the automatic enrollment takes place. Plan changes are also allowed at any time after automatic enrollment has happened. Changes to a new plan may take a month or two to become effective depending upon what day of the month the request was made. Expedited plan changes may be requested under certain circumstances.

***Advocacy note:** Advocates should be aware that the plans to which a person may be auto-assigned may not be the best choice for the person. It is always better to have the new CHC Participant call the IEB to learn about their choices and to be informed enough to select the best plan for their needs. Participants may need to be reminded that plan changes are allowed at any time.*

New Enrollees

When a CHC eligible person applies for Medicaid, they will be assisted in selecting a CHC-MCO (MCO = Managed Care Organization). Applying for and establishing eligibility for Medicaid can be challenging. The Aging and Disability Resource Centers (ADRCs) can help. See Appendix G for contact information. Once approved, Medicaid coverage begins on the date of the person's application.

Individuals who are applying for Medicaid LTSS will be counseled as to their plan choices as well as the LIFE option during the process of having their clinical eligibility evaluated. They will be advised to make an affirmative plan choice and, if they do not, they will be auto-assigned into a plan. CHC coverage begins on the date the person is determined eligible.

Individuals who are applying for Medicaid when they already have Medicare or people who are on Medicaid at the time they become eligible for Medicare will be sent notices providing them an opportunity to select a plan and, if they do not select a plan, will be auto-assigned.

***Advocacy note:** Advocates should be aware that the plans to which a person may be auto-assigned may not be the best choice for the person. It is always better to have the new CHC Participant call the IEB to learn about all their choices and to be informed enough to select the best plan for their needs or the LIFE program.*

What Plans are Participating in CHC?

There are three plans participating in Community HealthChoices (CHC). Each plan has a website and toll-free phone number through which it responds to Participant calls.

- 1) AmeriHealth Caritas (also known as Keystone First in Southeastern PA)
1-855-235-5115
(TTY: 1-855-235-5112)
www.amerihealthcaritaschc.com
- 2) PA Health & Wellness
1-844-626-6813
(TTY: 1-844-349-8916)
www.PAHealthWellness.com

3) UPMC Community HealthChoices
1-844-833-0523
(TTY: 1-866-407-8762)
www.upmchealthplan.com/chc

How to Choose the Right Plan?

The state has set most of the requirements for how plans operate and what services they may provide. As a result, the main differences between the plans may well come down to the network of providers participating in each plan, the ease of access to providers and getting approval for needed services, customer service, and any unique added plan benefits. For consumers who do not have Medicare Part D prescription drug coverage, the plan formulary of covered prescription medications may also be a critical factor.

While the state does pick a plan in to which it will automatically enroll eligible individuals who do not make an affirmative plan selection, it is preferable for an individual to select their plan. This can be done by calling the Independent Enrollment Broker's toll-free CHC Helpline at 1-844-824-3655 (TTY:1-833-254-0690), Monday through Friday from 8:00 AM to 6:00 PM. (Website: www.enrollchc.com) The Independent Enrollment Broker (IEB) can talk through a consumer's plan choices, specifically outlining which plans include which providers.

Consumers should call the IEB with a list of their physical health and LTSS providers handy. The IEB asks Participants to identify or select a primary care practitioner (PCP). They can change this PCP selection at any time.

Advocacy Note: *A Dual Eligible Participant is not required to have a network Provider as a PCP and must be permitted to designate their Medicare participating PCP as their CHC PCP.*

Can a Participant Leave CHC?

An eligible individual may only leave CHC if they are enrolling into LIFE (the Living Independence for the Elderly program) or choosing to no longer receive any Medicaid coverage at all.

Advocacy Note: *There are very few instances under which a person should be leaving CHC and also leaving the Medicaid coverage behind all together. One example would be if a significant increase in resources renders the individual no longer in financial need.*

LIFE is what Pennsylvania calls its federal Program for All-Inclusive Care for the Elderly (PACE) program. This model provides all Medicare, all Medicaid, and all long-term services and supports through an enhanced adult day health center while also providing in home services. There are currently 30 LIFE locations, each serving different geographic areas of Pennsylvania. Not all areas of the state are covered by LIFE locations. For information on where LIFE is available, click [here](#).

Advocacy Note: *A CHC Participant, age 55 or over, may choose to enroll in LIFE at any time, if available. Each LIFE program has an application process and may opt to deny an applicant's admission into the program. However, if denied, the consumer has the right to appeal this decision.*

How to Switch Plans?

Individuals who are enrolled in CHC and want to switch their plan may do so by calling the Independent Enrollment Broker (IEB), Maximus, via the toll-free CHC Helpline at 1-844-824-3655 (TTY:1-833-254-0690), Monday through Friday from 8:00 AM to 6:00 PM. The IEB can talk through a consumer's plan choices, specifically outlining which plans include which providers. Consumers should call the IEB with a list of their physical health and LTSS providers handy. A plan change can be requested at any time. The requested change will take effect on the first of the next month if made early in a month and on the first of the subsequent month (two months later), if change is made later in a month.

Advocacy note: *Advocates may wish to do a three-way call to the IEB with the consumer to help make sure all questions are answered.*

V. What Items and Services does CHC provide?

The CHC program covers Medicaid physical health services and long-term services and supports (LTSS). Many CHC Participants also have Medicare. Their Medicare coverage does not change unless the Participant opts to make a change in their Medicare coverage. Medicaid is the payor of last resort, meaning it pays last. So,

for Participants with Medicare, Medicaid is only responsible for physical health services not covered by Medicare, for Medicaid LTSS, and, possibly, for some balances due after Medicare covers its part, if Medicaid rules allow for further payment.

Advocacy Note: Consumers considering a change in their Medicare coverage may want to speak with an APPRISE counselor before making a change.

Medicaid Physical Health Services are Covered

The CHC program covers all of the Medicaid physical healthcare services that are available to eligible individuals through the Medicaid fee-for-service program.

This includes:

- 1) Inpatient Hospital Services
 - a) Inpatient Acute Hospital
 - b) Inpatient Rehabilitation Hospital
- 2) Outpatient Hospital Clinical Services including:
 - a) Outpatient Hospital Clinic
 - b) Outpatient Hospital Short Procedure Unit
 - c) Federally Qualified Health Center / Rural Health Clinic
- 3) Clinic Services including:
 - a) Independent Clinic
 - b) Maternity Clinic - Physician, Certified Nurse Midwives, Birth Centers
 - c) Renal Dialysis Services
 - d) Ambulatory Surgical Center (ASC) Services
- 4) Dental Services
- 5) Other Laboratory and X-ray Service including:
 - a) Laboratory
 - b) Radiology (For example: X- rays, MRIs, CTs)
- 6) Physical Therapy, Occupational Therapy, and Services for Individuals with Speech, Hearing, and Language Disorders
- 7) Nursing Facility Services including:
 - a) Skilled Nursing Facility
- 8) Family Planning Clinic Services and Supplies
- 9) Physician Services including:
 - a) Primary Care Provider Services
 - b) Physician Services and Medicaid and Surgical Services provided by a Dentist

- 10) Medical care and any other type of remedial care
 - a) Podiatrist Services
 - b) Optometrist Services
 - c) Chiropractor Services
- 11) Prescribed Drugs, Dentures, and Prosthetic Devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist
- 12) Diagnostic, Screening, Preventive, and Rehabilitative Services
 - a) Tobacco Cessation
 - b) Therapy (Physical, Occupational, Speech) – Rehabilitative
- 13) Certified Registered Nurse Practitioner Services
- 14) Home Health Services
 - a) Home Healthcare including Nursing, Aide and Therapy
 - b) Medical Supplies
 - c) Durable Medical Equipment
 - d) Therapy (Physical, Occupational, Speech)
- 15) Any other medical care and any other type of remedial care recognized under state law, specified by the Secretary of DHS
 - a) Ambulance Transportation
 - b) Non-Emergency Medical Transport (also known as the Medical Assistance Transportation Program)
 - c) Emergency Room
- 16) Hospice Care

For Participants that have Medicare, CHC-MCOs are also responsible for paying for Medicare cost-sharing as follows:

- 1) The CHC-MCO must pay Medicare deductibles (a specified amount of money that the individual must pay before Medicare will pay a claim) and cost-sharing (a share of the cost of the service the individual must pay, such as a co-payment with each visit) amounts relating to any Medicare-covered service for participants who have Medicare.
- 2) The CHC-MCO is not responsible for copayments or cost-sharing for Medicare Part D prescriptions.

Most services are defined in the Pennsylvania Medicaid State Plan.

Medicaid LTSS are Covered

CHC covers Medicaid Long Term Services and Supports (LTSS) previously available through OLTL's HCBS Waiver programs (the Aging Waiver, the Attendant Care

Waiver, the COMMCARE Waiver, the Independence Waiver, and the OBRA Waiver) as well as those previously available through Medicaid Fee-For-Services coverage of nursing facilities.

Medicaid LTSS include:		
Adult Daily Living	Home Delivered Meals	Personal Emergency Response System
Assistive Technology	Home Health Services (HH Aide, Nursing, PT, OT, Speech & Language Therapy)	Pest Eradication
Career Assessment	Job Coaching	Residential Habilitation
Community Integration	Job Finding	Respite
Community Transition Services	Non-Medical Transportation	Specialized Medical Equipment and Supplies
Employment Skills Development	Nursing Facility Services	Structured Day Habilitation
Exceptional Durable Medical Equipment (DME)	Participant-Directed Community Supports	TeleCare
Financial Management Services	Participant-Directed Goods and Services	Therapeutic and Counseling Services
Home Adaptations	Personal Assistance Services	Vehicle Modifications

Definitions for these services can be found in Appendix EE of the [Draft Community HealthChoices Agreement](#).

Medicaid Drugs are Covered

For Participants who do not have Medicare Part D prescription drug coverage, CHC provides the full Medicaid prescription and over the counter drug coverage. For Participants who do have Medicare Part D prescription drug coverage, Part D is the primary payor for prescription drugs. CHC provides a more limited pharmacy benefit that supplements the coverage Participants get through their Medicare Part D coverage.

Supplemental Benefits May be Offered

CHC-MCOs are permitted to provide additional services that are related to the goals of the CHC program. These are approved by the state.

Advocacy note: Each plan may offer different added benefits, and these may change over time. Current information about the differences among plans can be obtained from the IEB.

Nursing Home Transition and Money Follows the Person

CHC-MCOs must cooperate with and assist the Nursing Home Transition teams and the Money Follows the Person programs in helping Participants to transition out of institutions and into home and community-based services settings. All three MCOs offer an added benefit of special funding to assist Participants who are transitioning out of nursing facilities.

VI. Services That Are Not Covered By a CHC-MCO

While Community HealthChoices (CHC) covers all Medicaid physical health services and long-term services and supports, it does not provide coverage for all Medicaid services that Participants may need and for which Participants are eligible. For example, CHC Participants access behavioral health (BH) services and Medical Assistance Transportation Program (MATP) services outside of the CHC program. CHC-MCOs must coordinate with these other sources of coverage, and also with Medicare, to ensure Participants are getting needed services.

Advocacy note: Advocates will want to educate Participants about the requirement that CHC-MCOs must coordinate with services not provided directly by CHC. Advocates will also want to monitor how well the CHC-MCOs are doing this.

Behavioral Health Services

Generally, Medicaid covers behavioral health services for the population that participates in CHC. The CHC-MCOs, however, are not responsible for covering (or paying for) behavioral health services. As a result, CHC Participants must access these services through the separate HealthChoices behavioral health managed care organizations (BH-MCOs). Many Participants have Medicare, which also provides coverage of behavioral health services. These Participants must access their Medicare covered behavioral health through their Medicare coverage. As discussed above, the CHC-MCOs are required to coordinate their services with behavioral health services provided by the BH-MCO and/or Medicare.

Medicare Services

Many of the individuals who participate in the CHC program have both Medicare and Medicaid. Because the CHC Program is a Medicaid-only program, it does not provide Medicare coverage. Participants must choose or remain in a Medicare

option, if they are eligible for Medicare. Participants are free to stay with their current Medicare plan or may choose any available Medicare option including:

- 1) Original Medicare (Part A and B), also referred to as Traditional Medicare or Medicare Fee-For-Service, which would need to be accompanied by a Medicare Part D Prescription Drug Plan (Medigap or Medicare supplemental policies are not needed as Medicaid provides wrap-around coverage to Medicare through CHC.);
- 2) A Medicare Advantage plan (Part C) available in their service area; or
- 3) The Medicare Advantage Dual Eligible Special Needs Plan (D-SNP) offered by the company that offers their CHC-MCO as a companion to the CHC-MCO.

CHC-MCOs must coordinate with any Medicare plan in which the Participant is enrolled. There are coordination requirements imposed on all of the Medicare Advantage Dual Eligible Special Needs Plans (D-SNPs) that operate in the state (including the D-SNPs operated by the companies that offer the CHC-MCOs).

The state encourages CHC Participants to enroll in the Medicare Advantage Dual Eligible Special Needs Plan (D-SNP) offered by the company that offers their CHC-MCO as a companion to the CHC-MCO. The state believes that this provides additional opportunities for coordination. The state cannot require CHC Participants to join the companion D-SNP and neither can the CHC-MCO. Participants retain their Medicare freedom of choice at all times.

***Advocacy note:** Participants should contact the PA-SMP about any questionable marketing tactics, including any statements that a Participant must change Medicare coverage in order to participate in CHC. Contact information is provided in Appendix G.*

Participants should contact APPRISE for questions about their Medicare options. Please see Appendix G on helpful contacts for how to reach APPRISE.

***Advocacy note:** Participants should review their Medicare plan options at least once a year as coverage may change.*

Medical Transportation

CHC-MCOs provide emergency medical transportation and non-medical transportation. The pre-existing Medical Assistance Transportation Program (MATP) has not changed and it continues to provide non-emergency medical

transportation to CHC Participants. Participants and CHC-MCOs must coordinate non-emergency medical transportation needs with the MATP program for each Participant's county.

Advocacy note: Contact CARIE's Transportation Service Advocacy Program (T-SAP) with any questions or problems related to transportation or mobility management.

Hospice

For people with Medicare, hospice care is covered by Medicare. Participants who choose to have Hospice under Medicare are still eligible to remain in CHC and their CHC-MCO must continue to provide all required non-hospice services. For Participants who do not have Medicare, the CHC-MCO covers hospice services.

Advocacy note: Medicare hospice care may be approved for two 90-day benefit periods followed by an unlimited number of 60-day benefit periods. If a Participant is not approved for an additional benefit period and is discharged from Hospice, make sure the CHC-MCO is involved in discharge planning so that the CHC care plan can be adjusted or that the CHC-MCO is involved in helping the Participant to reapply for hospice care.

VII. How and When Are Needs Assessed and By Whom?

Participants' needs are assessed and re-assessed by the CHC-MCO on the timeline outlined by the state and using the state required assessment tool.

How are Needs Assessed?

The CHC-MCO must use the assessment tool required by the state to assess Participant needs. This comprehensive needs assessment, and annual reassessment tool, must assess physical health, behavioral health, social, psychosocial, environmental, caregiver, LTSS, and other needs as well as preferences, goals, housing, and informal supports. The comprehensive needs assessment and reassessment processes developed by the CHC-MCO must also capture the following:

- Need for traditional comprehensive care management of chronic conditions and disease management.
- Functional limitations, including cognitive limitations, in performing ADL and IADLs and level of supports required by the Participant.
- Ability to manage and direct services and finances independently.
- Level of supervision required.
- Supports for unpaid caregivers.
- Identification of risks to the Participant's health and safety.
- Environmental challenges to independence and safety concerns.
- Availability of able and willing informal supports.
- Diagnoses and ongoing treatments.
- Medications.
- Use of adaptive devices.
- Preferences for community engagement.
- Employment and educational goals.

Pennsylvania requires that the CHC-MCOs use the InterRAI Home Care assessment tool for comprehensive needs assessments and reassessments. This tool will be what the CHC-MCOs must use, at a minimum. CHC-MCOs are permitted to gather additional information not included in the required assessment tool.

Is the Eligibility Assessment Different from the Needs Assessment?

The needs assessment described just above is different from the eligibility assessment. All Applicants for LTSS must undergo an eligibility assessment to determine their functional eligibility for Medicaid coverage of LTSS. This will be done using the Functional Eligibility Determination (FED) tool (beginning in July 2018) prior to enrollment into CHC. The FED tool is not the same tool that is used to evaluate the Participant's needs and preferences.

When are Needs Assessed?

Every CHC Participant who is Nursing Facility Clinical Eligible (NFCE) must receive a comprehensive needs assessment from their CHC-MCO to help develop and implement a service plan to meet the Participant's needs.

Additionally, any Participant who requests a comprehensive needs assessment or articulates a need for LTSS must also be assessed. If the assessment reflects an unmet need for LTSS and the Participant is not receiving LTSS, the CHC-MCO must refer the Participant for a clinical eligibility determination. If the Participant is

determined to be clinically eligible, i.e., NFCE, a service plan will be developed and implemented.

Lastly, anytime the CHC-MCO or Independent Enrollment Broker (IEB) believes that a Participant has unmet needs, service gaps, or a need for service coordination, the CHC-MCO must conduct a comprehensive needs assessment.

The CHC-MCO will complete a comprehensive needs assessment in-person as follows:

- For Participants who are NFCE but are not receiving LTSS at the time of Enrollment, the comprehensive needs assessment must be completed no later than five (5) business days from the Effective Date of Enrollment.
- For Participants who are Dual Eligible and identified by the IEB as having a need for immediate services, the comprehensive needs assessment must be completed no later than five (5) business days from the Effective Date of Enrollment.
- For Participants who are identified as having unmet needs, service gaps, or a need for Service Coordination, the comprehensive needs assessment must be completed no later than fifteen (15) business days from the date the CHC-MCO is aware of the unmet needs, service gaps, or need for service coordination.
- For Participants with existing Person-Centered Service Plans (PCSPs) in place at the time of enrollment, the comprehensive needs assessment must be completed within 180 days of their Effective Date of Enrollment, except for Participants who are due for a level of care redetermination prior to the 180th day following their Effective Date of Enrollment must have a comprehensive needs assessment completed within five (5) business days of the level of care redetermination.
- When requested by a Participant or a Participant's designee or family member, the comprehensive needs assessment must be completed no later than fifteen (15) days from the request.

Who Conducts the Comprehensive Needs Assessment?

A service coordinator will conduct the comprehensive needs assessment. During the initial 180-day transition period, the service coordinator can be the same service coordinator the Participant was using before enrolling in CHC.

When are Needs Re-assessed?

A comprehensive needs reassessment must be conducted no more than 12 months after the most recent assessment or reassessment but may have to be done sooner if a trigger event occurs. Reassessments must be completed as soon as possible but no more than 14 days after the occurrence of any of the following trigger events:

- A significant healthcare event such as a hospital admission, a transition between healthcare settings, or a hospital discharge.
- A change in functional status.
- A change in caregiver or informal supports if the change impacts one or more areas of health or functional status.
- A change in the home setting or environment if the change impacts one or more areas of health or functional status.
- A change in diagnosis that is not temporary or episodic and that impacts one or more area of health status or functioning.
- As requested by the Participant or designee, the caregiver, the provider, or the Person-Centered Planning Team (PCPT) or PCPT Participant, or the state.

VIII. How and When Are Care Plans Developed and By Whom?

Who Gets Care Management?

The CHC-MCOs must provide care management to all Participants. Generally, care management is a set of activities intended to improve patient care and reduce the need for medical services. It involves coordinating care, eliminating duplication of services, and helping consumers better manage this health conditions. The term care management is not explicitly defined for the CHC program. CHC-MCOs are not required to develop a written care plan or Person-Centered Service Plan (PCSP) for all Participants, however.

Who Gets a Care Plan?

The CHC-MCOs must develop and implement a written care plan for:

- 1) Participants who do not require LTSS but who have unmet needs, service gaps, or a need for Service Coordination, AND
- 2) Participants who require LTSS. Please note that this "Care Plan" (described next) is part of the Person-Centered Service Plan (PCSP) which CHC-MCOs

must create for all participants who receive LTSS (described below after “care plan”).

What Must be in a Care Plan?

The Care Plan is required to specifically lay out how the Participant’s physical, cognitive, and behavioral healthcare needs will be care managed.

The care plan for Participants who do not require LTSS, at a minimum, must include:

- Active chronic problems, current non-chronic problems, cognitive needs, and problems that were previously controlled or classified as maintenance care but have been exacerbated by disease progression or other intervening conditions.
- Current medications.
- All services that are being authorized and the scope and duration of the authorization. This must include both those services previously authorized in the prior care plan as well as any services the CHC-MCO authorized since the last care plan was draft and that need to be continued.
- A schedule of preventive service needs or requirements.
- Disease management action steps.
- Known needed physical and behavioral health care and services.
- All designated points of contact and the Participant’s authorizations of who may request and receive information about the Participant’s services.
- How the care manager or service coordinator, if applicable, will assist the Participant in accessing Covered Services identified.
- How the CHC-MCO will coordinate with the Participant’s Medicare, Veterans, BH-MCO, Lottery-funded Services such as OPTIONS, and/or other health coverage.

Who Gets a Person-Centered Service Plan (PCSP)?

Participants who require LTSS must have a PCSP. CHC-MCOs are not required to develop a PCSP for Participants who do not require LTSS. They are, however, permitted to develop a PCSP for any Participant if they so choose.

What Must be in the PCSP?

- 1) There are a number of requirements for the Person-Centered Service Plan (PCSP).
- 2) It must be written, understandable, and comprehensive.

- 3) It must comply with all requirements in the federal regulations found at 42 CFR 441.301(c)(1)-(3).
- 4) It must contain a Care Plan, or all the elements of a Care Plan - as described just above. This should identify how their physical, cognitive, and behavioral healthcare needs will be care managed.
- 5) It must identify how the LTSS needs will be met and how the Service Coordinator will ensure that services are provided in accordance with the PCSP.
- 6) The LTSS Service Plan section of the PCSP must:
 - a) List all LTSS services necessary to support the Participant to live as independently as possible and remaining as engaged in their community as possible.
 - b) Account for the needs identified in the comprehensive needs assessment, articulating all of the interventions to address each need or preference, reasonable long-term and short-term goals, the measurable outcomes to be achieved by the interventions, the anticipated time lines in which to achieve the desired outcomes, and the staff responsible for conducting the interventions and monitoring the outcomes.
 - c) Identify potential problems that can be anticipated, including the risks and how these risks can be minimized to foster the Participant's maximum functioning level of well-being.
 - d) Contain Participant decisions around self-directed care and whether the Participant is participating in Participant-Direction.
 - e) Outline the communications plan.
 - f) Detail how frequently specific services will be provided.
 - g) Specify whether and how technology and telehealth will be used to help the Participant.
 - h) State the Participant choice of Providers.
 - i) Include the details of the Participant's Individualized Back-Up Plan.
 - j) List the person(s)/Providers responsible for specific interventions/services.
 - k) Note the Participant's available, willing, and able informal support network and services.
 - l) Lay out the Participant's need for and plan to access community resources, non-covered services, and other supports, including any reasonable accommodations.
 - m) Outline how to accommodate preferences for leisure activities, hobbies, and community engagement.

- n) Detail any other needs or preferences of the Participant.
- o) State the Participant's goals for the least restrictive setting possible, if they are being discharged or transitioned from an inpatient setting.
- p) Specify how the CHC-MCO will coordinate with the Participant's Medicare, Veterans, BH-MCO, other health coverage, and other supports.
- q) Include the Participant's employment and educational goals.
- r) List any need for referrals or need for assistance in obtaining referrals.

How are PCSPs Developed?

Service Planning for Participants who require LTSS is done by the Participant's Service Coordinator, the Participant, and the Participant's Person-Centered Planning Team (PCPT). This team is individualized for the Participant and is responsible for development and implementation of the Participant's Person-Centered Service Plan (PCSP). The specifics of how each CHC-MCO will implement the requirement to use a PCPT approach is left for each CHC-MCO plan to design and submit to the state for approval. The CHC-MCO PCPT approach must be person-centered and must take into account all goals and requirements of CHC.

Information is available online about person-centered planning and the importance of this process being conducted properly. According to Justice in Aging, "Person-centered planning encompasses the idea that the individual is at the heart of all decisions about services, supports, and care. The focus of PCP planning should be the goals, wants, needs, and strengths of the individual." The Participant should lead the person-centered planning process whenever possible and be empowered to make informed choices about their service plan. Each service plan should be unique and personalized to the Participant in contrast to a "cookie cutter" approach to avoid service plans looking very similar within a MCO.

Advocacy Note: *Advocates should push for service planning that is truly person-centered and addresses the Participant's life goals, unique needs, and preferences. Participants should be supported to make their own choices about how they want to live. Advocates should monitor to be sure service plans are not reduced and that service plans meet Participant needs. Advocates may need to support Participants through grievance or appeals processes to get needed services and support.*

CHC-MCOs are not required to use the PCPT approach for Participants who do not require LTSS, as they are for Participants who require LTSS. They are, however, *permitted* to use this approach for Participants who do not require LTSS.

When is the PCSP Developed?

PCSPs must be completed no more than 30 days from the date the comprehensive needs assessment or reassessment is completed.

Can a PCSP be Appealed?

Yes. A Participant or other person acting on behalf of a Participant may appeal a Person-Centered Service Plan (PCSP), even if the Participant was involved in the meetings and discussions that led to the creation of the PCSP. Additionally, the state may review, question, and request the revisions of any PCSP.

Advocacy Note: There are many reasons a participant may want to appeal including that they do not believe the service plan will meet their daily needs.

IX. Service Coordinators

Participants who require LTSS or have a Person-Centered Service Plan (PCSP) must have a designated service coordinator to implement and coordinate the services called for in the PCSP or care plan. CHC-MCOs are free to provide a service coordinator to other Participants who do not require LTSS.

The Role of the Service Coordinator

Service coordinators help Participants get what they need. Service coordinators lead the Person-Centered Service Planning (PCSP) process and oversee the implementation of PCSPs.

Service coordinators identify, coordinate and assist Participants in getting needed LTSS services and State Plan services as identified in their PCSPs and as may arise between PCSPs. They are also required to assist Participants in accessing non-Medicaid funded medical, social, housing, educational, and other services and supports.

Service coordinators also help the Participant and their Person-Centered Service Planning Team in selecting providers and coordinating with the Participants'

behavioral health managed care plan. Additionally, service coordinators help Participants' in maintaining eligibility for Medicaid and accessing benefits through other coverage such as Medicare and/or private insurance or other community resources.

Choice of Service Coordinator

CHC-MCOs must provide a choice of service coordinators. This may be a choice of CHC-MCO employees or a choice that includes contracted service coordination entities. CHC-MCOs can provide all service coordination through their own employees, may contract with service coordination entities, or use a combination of the two options. All three CHC-MCOs have announced plans to use both staff/employees as service coordinators and to contract with service coordination entities to provide this service. At any time, a Participant may choose to change the service coordinator that they selected or that was assigned.

Participants who are transitioning from an HCBS waiver program into CHC for the first time at the start of enrollment in their CHC zone will have at least 180 days of continuity of care for their service coordination services. They will have 180 days or until their Person-Centered Service Plan (PCSP) is completed, whichever is later. Participants who transfer from one CHC-MCO to another during their first 180 days of enrollment in CHC will get the greater of the remainder of the full 180 days from the date they first enrolled in CHC or 60 days from the date of their plan transfer or until a new PCSP has been created by the new plan, whichever date is later. After the first 180 days on CHC, the service coordination function must be provided by an appropriately qualified service coordinator employed by or under contract with the Participant's CHC-MCO.

X. Which Providers Can Participants Use?

Participating Providers

Participating providers are those healthcare providers that have a contract with the CHC-MCO to be part of the CHC-MCO's network. Generally, Participants are required to use the Participating Providers within the CHC-MCO's network. Under certain circumstances, such as with Medicare, Participants may use out-of-network or non-participating providers.

The rules generally guarantee a choice of participating providers and permit Participants to use any participating providers in the network. Participants must

select their Primary Care Practitioner (PCP). Participants who have Medicare are not required to have a network provider as their PCP and the CHC-MCO must permit them to designate their Medicare PCP as their PCP. Participants who do not have Medicare must select a participating provider with the Participant's CHC-MCO network, unless the CHC-MCO has granted an exception, or one will be assigned for them. In most circumstances, the Participant may change their assigned or selected PCP at any time by calling the plan.

Each CHC-MCO has its own network. While there is overlap across the three plans' networks, it is important for individuals to consider which plans include their providers as they are choosing the CHC-MCO plan that will best meet their needs.

Non-Participating Providers

Participants may not use providers who do not have a contract with the Participant's CHC-MCO when they are obtaining CHC covered services, except in limited circumstances such as when the CHC-MCO cannot offer a choice of two qualified specialists, when the CHC-MCO does not have an adequate number of providers within the time and distance requirements, or when Participants hire their own aides.

***Advocacy note:** The Pennsylvania Health Law Project, Community Legal Services, or other local legal services programs should be contacted if a Participant needs help to access non-participating providers.*

Hiring One's Own Aides or Attendants

Some individuals can hire their own personal care aides/attendants if the Participant has chosen to receive self-directed services through the Consumer-Employer Authority or Services My Way program. These two options were not changed under CHC. Through these options, Participants can hire and fire their own personal care aides, can control the scheduling of these aides, and control the payment to these aides. This may also include hiring family members or neighbors to provide personal assistance services. The aides do not have to be participating providers of a CHC-MCO, but a criminal background check is required of the aide/attendant. The Participant has the right to decide whether to employ the person after reviewing the results.

***Advocacy Note:** While these options work well for many, these programs also have a risk for fraud and abuse. Some aides see this*

as an opportunity to meet welfare work requirements or to collect a paycheck without providing any services. These situations may mean a Participant is being neglected or even abused. Advocates should report cases where care is not being provided immediately to the Participant's service coordinator or to the CHC-MCO. In cases where imminent harm or abuse is suspected, contact protective services – Older Adult Protective Services (OAPS) for people 60 and over or APS for those under 60.

Rules About Provider Networks

Each CHC-MCO must have Networks of providers that meet the needs of their Participants. There are some set rules that are designed to ensure access and adequacy. These are located in [Appendix BB of the Draft Agreement](#) but some key rules are highlighted in the following chart and throughout this section.

Primary Care Practitioners (PCPs)

Participants must have a choice of at least two (2) PCPs with open panels.	PCP offices must be located within a travel time no greater than 30 minutes for urban areas and 60 minutes for rural areas.	Travel time is measured using public transportation estimates in areas with public transportation.
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Participants must have a choice of at least two (2) PCPs with open panels whose offices are located within a travel time no greater than thirty (30) minutes for urban areas and sixty (60) minutes for rural areas. This travel time is measured via public transportation in areas where public transportation is available. Participants may, at their discretion, select PCPs located further from their homes. (Medicare beneficiaries may have a PCP that is not part of the CHC network, but the PCP must be enrolled in the PA Medical Assistance Program so the CHC plan may cover any co-pay costs.)

Specialists

Participants must have a choice of at least two (2) of each type of Specialist and the Specialists must be accepting new patients.	Specialists offices must be located within a travel time no greater than 30 minutes in urban areas and 60 minutes in rural areas.	Travel time is measured using public transportation estimates in areas with public transportation.
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Participants must have a choice of at least two (2) of each type of Specialists who are accepting new patients within the travel time limits of thirty (30) minutes in urban areas and sixty (60) minutes in rural areas. This travel time is measured via public transportation in areas where there is public transportation available. (Medicare beneficiaries may see Medicare Specialists that are not part of the CHC network, but the Specialist must be enrolled in the PA Medical Assistance Program so the CHC plan may pay for any Medicaid related co-pay costs.)

Hospitals

Participants must be ensured access to at least one (1) hospital within the travel time limits and a 2 nd choice of hospital within the CHC zone.	One (1) hospital must be located within a travel time no greater 30 minutes in urban areas and 60 minutes in rural areas. A 2 nd hospital must be located within the CHC zone.	Travel time is measured using public transportation estimates in areas with public transportation.
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Participants must be ensured access to at least one (1) hospital within the travel time limits (i.e., thirty (30) minutes in urban areas and sixty (60) minutes in rural areas) and a second (2nd) hospital choice within the CHC zone. This travel time is measured via public transportation, where available.

LTSS Providers

Participants must have a choice of at least two (2) providers for each LTSS covered service within the travel time limits.	LTSS Providers offices must be located within a travel time no greater than 30 minutes in urban areas and 60 minutes in rural areas.	Travel time is measured using public transportation estimates in areas with public transportation.
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Participants must have a choice of at least two (2) Providers for each LTSS covered service within the travel time limits (thirty (30) minutes for urban areas and sixty (60) minutes for rural areas).

Advocacy note: *It is not enough for the CHC-MCOs to have the required number of specialists or subspecialists in their network.*

These specialists or subspecialists must be accepting new patients and must be qualified to meet the specific needs of the individual Participant. If the CHC-MCO does not have at least two (2) specialists or sub-specialists who meet these specific requirements that are within the travel time requirements, then the CHC- MCO must allow Participants to pick an Out-of-Network or Non-Participating Provider.

Appointment Standards

CHC-MCOs must ensure that PCPs meet the following appointment standards:

- 1) Emergency Medical condition cases must be immediately seen or referred to an emergency facility.
- 2) Urgent Medical Condition cases must be scheduled within twenty-four (24) hours.
- 3) Non-Urgent Sick Visits with a PCP must be scheduled within seventy-two (72) hours of request, as clinically indicated.
- 4) Routine appointments must be scheduled within ten (10) business days.
- 5) Health assessment/general physical examinations and first examinations must be scheduled within three (3) weeks of Enrollment.

CHC-MCOs must be able to provide visits to Specialists within the following appointment standards:

- 1) Emergency Medical Condition appointments must be seen immediately upon referral.
- 2) Urgent Medical Condition care appointments within twenty-four (24) hours of referral.
- 3) Scheduling of appointments for routine care shall be scheduled to occur within thirty (30) days for all specialty Provider types.

Wait Times

The CHC-MCO must ensure that Participants' average office waiting time for an appointment for Routine Care is no more than thirty (30) minutes or at any time no more than up to one (1) hour when the physician encounters an unanticipated Urgent Medical Condition visit or is treating a Participant with a difficult medical need. The Participant must be informed of scheduling time frames through educational outreach efforts.

Provider Directories

CHC-MCOs must maintain lists of all the providers in their network. These lists, called Provider Directories, are usually posted on the CHC-MCO's website. The IEB also has access to provider directories. Networks can change frequently, and, for that reason, Provider Directories should be updated often.

***Advocacy note:** Advocates should know that there is always a risk that a provider directory is out of date or contains inaccurate information. When helping Participants, it is helpful to call the IEB or the CHC-MCO directly and confirm whether a provider is in the CHC-MCO network and accepting new Participants.*

XI. What Continuity of Care is Provided?

As with all Medicaid managed care programs, the state requires the CHC-MCOs to provide continuity of care. Continuity of care is protection against interruptions in services or care received during the period when one is transitioning into a new managed care plan.

There is one rule for continuity of care that applies to most of the services. In addition, there are additional protections for nursing facility residents and individuals who are receiving Home and Community-Based Waiver services at the time CHC enrollment begins in their zone.

Continuity of Care for Most Services

CHC-MCOs must allow Participants to use the same healthcare providers and to continue to receive any ongoing courses of treatment for at least the first 60 days of enrollment into a CHC-MCO. This is based on state law and applies both to a first-time enrollment into CHC as well as when a Participant transfers from one CHC-MCO to another. (The requirements are outlined in Section 2117 of Article XXI of the Insurance Company Law of 1921, as amended, 40 P.S. §991.2117, regarding continuity of care requirements and 28 PA Code §9.684 and 31 PA Code §154.15 and also Medical Assistance Bulletin 99-03-13, Continuity of Care for Recipients Transferring Between and Among Fee-for-Service and Managed Care Organizations.)

Continuity of Care for Nursing Facility (NF) Residents

An individual who resides in a nursing facility and is receiving nursing facility care that is being paid for by Medicaid at the time CHC begins for the first time in the resident's zone may continue to receive nursing facility services from the same nursing facility, even if the nursing facility never joins the CHC-MCO into which the Participant enrolls, for as long as the Participant remains eligible for Medicaid nursing facility care. This means that a nursing facility resident may enroll in any CHC-MCO, regardless of whether their nursing facility is a participating nursing facility in that CHC-MCO.

Advocacy note: *Advocates should make sure nursing facility residents who are CHC Participants, when CHC begins in their zone, understand that they cannot be made to move from one nursing facility to another. If you encounter a situation in which a nursing facility resident is being transferred against their will, contact CARIE or your local LTC Ombudsman for help.*

Consequently, a CHC-MCO must pay any nursing facility in which a new Participant is residing and receiving Medicaid nursing facility services at the time CHC enrollment begins in their zone. This continuity of care protection lasts until:

- 1) The Participant chooses to return to their home or other home or community-based setting.
- 2) The Participant chooses to transfer to a different nursing facility (NF).
- 3) The Participant is disenrolled from CHC by the Department of Human Services.
- 4) The Participant Is determined by their physician to no longer need NF services.
- 5) The NF transfers or discharges the Participant in accordance with 42 CFR § 483.12(a); provided that, if the Participant appeals their transfer or discharge, the continuity of care period will continue until the Participant's appeal is adjudicated by the Department's Bureau of Hearings and Appeals.
- 6) The NF is no longer certified to participate as a provider in the MA Program.

Advocacy note: *A change in CHC-MCO, a temporary hospitalization or therapeutic leave does not interfere with or end this continuity of care period as long as the Participant remains a resident of the NF they were in at the time of enrollment into CHC. All NH regulations*

still apply to all residents such as having an appropriate care plan in place upon discharge and proper notice. Contact the local LTC Ombudsman for any issues of concern.

Participants who are admitted to a NF after enrolling into CHC will instead receive the 60-day continuity of care period described above in "Continuity of Care for Most Services."

Continuity of Care for Waiver HCBS: When CHC Starts in a Zone

A Participant who is participating in a HCBS Waiver program up until their first day of enrollment into CHC will have continuity of care for a period of 180 days starting on that first day of enrollment or until a comprehensive needs assessment has been completed and a PCSP has been developed and implemented, whichever date is later. During this first 180 days, the Participant must be provided all LTSS previously authorized through all providers currently being used (including care managers or service coordinators). After the 180 days, the Participant must use the CHC-MCO network of providers and will receive the services identified in the CHC-MCO assessment and service planning process.

***Advocacy note:** Providers that a Participant was using before enrolling into the CHC-MCO may or may not be a Participating Provider with the CHC-MCO. While the continuity of care period will ease the transition, be sure to have the Participant check the plan network during this time to see if they can keep their LTSS providers after the continuity of care period ends. If not, they may want to evaluate whether to pick a different plan that does include their LTSS providers in its network.*

A Participant who changes CHC-MCOs during their first 180 days in CHC will receive the previously authorized services from their prior providers for 1) the greater of 60 days or the remainder of the 180 days or 2) until a comprehensive needs assessment has been completed and a PCSP been developed and implemented, whichever date is later.

If a Participant changes CHC-MCOs after their initial 180-day Continuity of Care period, the receiving CHC-MCO will provide continuity of care for 60 days or until a comprehensive needs assessment has been completed and a PCSP been developed and implemented, whichever date is later.

XII. How to Get Services in CHC

Generally, services must be obtained from CHC-MCO providers and by following procedures outlined by the CHC-MCO. This is not the case if the Participant is in their continuity of care period, has permission to use out-of-network providers, or is taking advantage of the self-directed model for accessing some LTSS services through their own providers.

How to Request a Service

A Participant can request a service or item at any time. This can be done directly through contact with a CHC-MCO Participant service representative by calling the plan's toll-free Participant Services Line or through one's service coordinator. A service request can also be made by any provider requesting something for the Participant or through discussions with their PCPT.

In managed care, the Participant or their provider must **obtain the CHC-MCO's prior approval or permission ahead of time** to get most services. This is called prior authorization. The prior authorization process may require a Participant or their provider to submit certain information so that the CHC-MCO can determine whether the item or service is necessary. A Participant may access some services directly without having to request it through their PCP or MCO such as visits to their PCP, vision or dental care, and gynecological (OB/GYN) services.

Sometimes a CHC-MCO will require that a Participant try other items or services first before it will approve what was requested. If the CHC-MCO does not agree to authorize an item or service, the Participant, anyone acting on the Participant's behalf, or the Participant's provider can appeal using the process described in Section XIV below.

Rules for Coverage

CHC-MCOs must cover services and items that the state requires them to cover and that the Participant needs. For healthcare services, the CHC-MCO must evaluate whether the service or item is Medically Necessary for the Participant. The Medical Necessity standard is not applied for LTSS services. For LTSS, the service must be needed.

Advocacy note: Remember that Medical Necessity is not required for LTSS and that CHC-MCOs may not require a request for LTSS to meet the Medical Necessity standard. Call local legal services, Community Legal Services, or the Pennsylvania Health Law Project if a CHC-MCO does not appear to be following this rule.

CHC-MCOs may require Participants to get referrals or to obtain permission ahead of time (called prior authorization) and some of these rules and procedures may differ by plan. If a Participant does not follow the CHC-MCO's rules for how to obtain services, service might be denied. If the services are denied, an appeal may be filed using the process described in Section XIV below.

How to Schedule an Appointment

Appointments can be made by calling the provider and requesting the appointment. If the Participant needs assistance in scheduling their appointments, the Participant's PCSP or care plan should include what assistance will be provided and by whom.

Trouble Getting Services

Participants who are having trouble getting the services they need should file a complaint with their CHC-MCO and the state. If they have requested services that have been denied, they should appeal. There are many organizations available to assist Participants who are not getting what they need. A list of these can be found in Section XVI.

XIII. Participant Rights

Participants have many rights. Some rights are specifically outlined in the agreement that the CHC-MCO signed with the state. Other rights are not stated in the agreement but through existing laws that grant these rights. Finally, other rights are CHC-specific rights that derive from the requirements the CHC-MCOs must meet for the benefit of the Participants. One example would be the right to receive those services that are medically necessary. This right derives from the CHC-MCO's obligation to provide the participant with medically necessary services.

Rights Specifically Outlined for CHC

A Participant has the right to:

- Receive information in accordance with [42 C.F.R. § 438.10](#) (relating to limited English proficiency, alternative format and substantive and procedural requirements);
- Be treated with respect and with due consideration for their dignity and privacy;
- Receive information on available treatment options and alternatives, presented in a manner appropriate to the enrollee's condition and ability to understand.
- Participate in decisions regarding their care and services, including the right to choose Network Providers and to choose Service Coordinator and the right to refuse treatment;
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in other Federal regulations on the use of restraints and seclusion;
- Request and receive a copy of their service records, and request that they be amended or corrected, if the privacy rule, as set forth in 45 CFR parts 160 and 164 subparts A and E, applies (See [45 CFR §§ 164.524](#) [relating to Access of individuals to protected health information] and [164.526](#) [relating to Amendment of protected health information]); and,
- Be furnished services in accordance with [§§ 438.206](#) through [438.210](#) (about availability of services, assurances of adequate capacity and services, coordination and continuity of care, and coverage and authorization of services).

Each Participant is free to exercise their rights, and the exercise of those rights may not adversely affect the way the CHC-MCO and its providers treat the enrollee.

CHC-MCO must comply with any other applicable Federal and State laws (such as: Title VI of the Civil Rights Act of 1964 as implemented by regulations at 45 CFR part 80; the Age Discrimination Act of 1975 as implemented by regulations at 45 CFR part 91; the Rehabilitation Act of 1973; and Titles II and III of the Americans with Disabilities Act; and other laws regarding privacy and confidentiality).

Medicare Rights

CHC Participants who have Medicare retain all their Medicare rights, including their right to choose the Medicare coverage they want, the right to change their Medicare plan monthly because they have Medicare and Medicaid, and the right

to receive all the Medicare services available to them. CHC Participants who have Medicare are protected from unlawful balance billing by providers and are protected against unlawful marketing practices.

Language Access Rights

CHC-MCOs must ensure that language is not a barrier to care. To this end, CHC-MCOs must identify Participants who speak or read a language other than English as their first language and their preferred language for spoken and written communications. The CHC-MCOs must provide, at no cost to Participants, oral interpretation services in the requested language or sign language interpreter services to meet the needs of Participants.

CHC-MCOs must require their Network Providers to offer interpretation services and prohibit Network Providers from requiring a Participant's family member be used for interpretation. If a Network Provider is unable or unwilling to provide these services, the CHC-MCO must provide interpretation services. The CHC-MCO must make all vital documents disseminated to English speaking Participants available in the prevalent languages designated by the Department. (Spanish, Chinese, Cambodian, Vietnamese and Russian) The CHC-MCO must include appropriate instructions in all materials about how to access or receive assistance to access materials in an alternate language. These 15 languages must be in the taglines: Spanish, Chinese, Vietnamese, Russian, Pennsylvania Dutch, Korean, Italian, Arabic, French, German, Gujarati, Polish, French Creole (Haitian Creole) Cambodian, and Portuguese. The CHC-MCO must post vital documents on its website.

Cultural Competency Requirements

CHC-MCOs are required to provide culturally competent care. This means that providers should be knowledgeable about the cultural differences of the diverse population they serve. CHC-MCOs also must ensure that their staff are culturally competent. This means that each CHC-MCO's staffing should represent the racial, ethnic, LGBT, and cultural diversity of the Participants being served by CHC. Additionally, the state requires the CHC-MCOs to continually expand cultural knowledge and resources with regard to the populations served, collaborate with the community regarding service provision and delivery, commit to cross-cultural training of staff and the development of policies to provide relevant, effective programs for the diversity of people served.

Accessibility Rights

CHC-MCOs must make care accessible to Participants, regardless of ability or disability. They are required to follow the requirements of the Americans with Disabilities Act. This means providers' offices and other service locations must be accessible.

Additionally, the state requires that all written materials and communications from the CHC-MCO must be accessible to Participants. Specifically, the CHC-MCO must provide alternative methods of communication for Participants who have neurocognitive impairments or who are visually or hearing impaired or both, including Braille, audio tapes, large print, compact disc, DVD, computer diskette, special support services, and/or electronic communication. When requested, the CHC-MCO must make all written materials disseminated to Participants accessible to visually impaired Participants. The CHC-MCO must provide TTY and/or Pennsylvania Telecommunication Relay Service for communicating with Participants who are deaf or hearing impaired, upon request. The CHC-MCO must include appropriate instructions in all materials about how to access or receive assistance to access materials in an alternate format.

Facility-Based Rights

Participants who reside in a Nursing Facility, Assisted Living Residence, Personal Care Home, Domiciliary Care Home, or other residential setting retain all the rights afforded to a resident in those facilities. Participants who attend facilities for services such as an Adult Day Services Center or to have procedures at an inpatient or outpatient facility have all the rights afforded by the rules regulating those facilities.

***Advocacy note:** If you are uncertain what are the residents' rights in a specific long-term care facility, please contact CARIE or your local LTC Ombudsman. If you are uncertain what other facility-based rights exist, please contact the Pennsylvania Health Law Project.*

Other CHC Rights due to CHC-MCO Obligations to Participants

The CHC-MCO signed an agreement with the state that mandates that it do certain things and provide specific services, including those outlined in this handbook, for the benefit of the Participants. Because these requirements are for the benefit of the Participants, the Participants have a right to receive these from the CHC-MCO. Some examples include:

- The right to receive medically necessary items and services as needed to meet the Participant's need.
- The right to participate in care planning and the development of a Person-Centered Service Plan.
- The right to have needs assessed in accordance with the requirements of the CHC program, including the right to request a reassessment.
- The right to involve caregivers or family members in treatment discussions and decisions.
- The right to choose of at least 2 providers within the time and distance standards outlined in section "X." above.

Participants' Responsibilities

According to the Agreement between the states and the CHC-MCOs, Participants (or their responsible party) also have the following responsibilities:

- To review Covered Items and Services and the rules around getting Covered Items and Services;
- To tell Providers that they are enrolled in a CHC-MCO and show their CHC-MCO ID card;
- To treat Providers and employees of the CHC-MCO with respect and to refrain from any type of abusive behavior towards Providers or employees of the CHC-MCO;
- To communicate problems immediately to the CHC-MCO;
- To keep appointments or notify the Service Coordinator if an appointment cannot be kept;
- To supply accurate and complete information to the CHC-MCO's employees;
- To actively participate in PCSP development and implementation;
- To notify the CAO and the CHC-MCO of any changes in income and assets. Assets include bank accounts, cash in hand, certificates of deposit, stocks, life insurance policies, and any other assets;
- To ask questions and request further information regarding anything not understood;
- To use the CHC-MCO's Network Providers for services included in the CHC-MCO Benefit Package;
- To notify the CHC-MCO of any change in address or lengthy absence from the area;
- To comply with all policies of the CHC-MCO as noted in the Participant Handbook;

- If sick or injured, to call their doctors, the nurse hotline, or their service coordinators for immediate directions;
- In case of emergency, to call 911; and
- If Emergency Services are required out of the service area, to notify the CHC-MCO as soon as possible.

Right to Voice Concerns to CHC-MCOs

At any time, a Participant may file a complaint against their CHC-MCO. Participants may also communicate concerns through the CHC-MCO's Participant Advisory Committee meetings during which Participants are provided an opportunity to share concerns.

Other Rights

Participants maintain all other rights afforded to them in state or federal law, such as health privacy rights and more.

Advocacy note: Just because these rights may not be specifically outlined in materials from the state or the CHC-MCO does not mean these rights have been lost.

XIV. Complaints, Grievances, and Fair Hearings

There are state requirements for how CHC-MCOs must handle Participant complaints, grievances, and Fair Hearings.

Advocacy note: See Glossary for definitions of Complaints, Grievances, and Fair Hearings.

The CHC-MCO Complaint, Grievance, and Fair Hearing processes are only available for decisions made by the CHC-MCO. Medicare decisions are separately handled through the Participant's Medicare coverage and other Medicaid decisions, such as decisions about Medicaid behavioral health services or decisions about eligibility, may be challenged separately as well.

Several entities are available to assist with complaints, grievances, and Fair Hearings. These are listed in Section XVI "Where to turn for help".

The requirements for CHC Complaints, Grievances, and Fair Hearings are identical to the processes for HealthChoices, the longstanding Medicaid managed care program for Medicaid consumers who are not eligible for CHC. The requirements have recently been updated based on changes in federal Medicaid Managed Care regulations but, the changes are incorporated into this Handbook.

Below is a summary of the Complaint, Grievance, and Fair Hearings processes.

***Advocacy note:** Advocates may wish to be familiar with the details of these processes and, so we have provided the full text of the requirements of the Complaint, Grievance, and Fair Hearing processes as outlined in the CHC-MCO Draft Agreement Exhibit G in Appendix C below.*

Complaint Process

First Level Complaint Process

A Participant can file a complaint with their CHC-MCO orally or in writing. A representative with written proof of the Participant's authorization for the representative to be involved and/or act on the Participant's behalf may file instead. Some Complaints must be filed within sixty (60) days from the date of the incident complained of or the date the Participant receives written notice of the decision. For all other Complaints, there is no time limit for filing a Complaint.

If the Complaint is to dispute a decision to stop, reduce, or change a service/item that the Participant has been receiving on the basis that the service/item is not a covered benefit and the Complaint is hand delivered or postmarked within ten (10) days from the mail date on the written notice of decision, the CHC-MCO must continue to provide the disputed service/item at the previously authorized level pending resolution of the Complaint. This is often called "continuing benefits pending appeal" or "aid paid pending".

***Advocacy note:** Advocates should encourage Participants to file their Complaints expeditiously and may want to follow-up with the Participants or their CHC-MCO to make sure continuing benefits are being provided.*

The CHC-MCO must provide the Participant an opportunity to present evidence, and allegations of fact or law, in person as well as in writing. The CHC-MCO shall

be flexible when scheduling the review to facilitate the Participant's attendance. The Participant shall be given at least seven (7) days advance written notice of the review date. If the Participant cannot appear in person at the review, the CHC-MCO must provide an opportunity to communicate with the first level Complaint review committee by telephone or video conference. The Participant may elect not to attend the first level Complaint meeting, but the meeting must be conducted with the same protocols as if the Participant was present.

The first level Complaint review committee shall complete its review of the Complaint as expeditiously as the Participant's health condition requires, but no more than thirty (30) days from receipt of the Complaint, which may be extended by fourteen (14) days at the request of the Participant. These timeframes are shorter if the Participant requests an **Expedited Complaint Decision**. A Participant may request an Expedited Complaint Decision orally or in writing at any point prior to the second level Complaint decision if they provide the CHC-MCO with a signed certification from the Participant's Provider that the Participant's life, health or ability to attain, maintain or regain maximum function would be placed in jeopardy by following the regular Complaint process.

An Expedited Complaint Decision must be rendered within either forty-eight (48) hours of receiving the Provider certification or seventy-two (72) hours of receiving the Participant's request for an expedited review, whichever is shorter. In addition, the CHC-MCO must mail written notice of the decision to the Participant, the Participant's representative, if the Participant has designated one, and the Participant's Healthcare Provider within two (2) business days of the decision, using the required notice.

If a Participant disagrees with the CHC-MCO First Level Complaint decision, the Participant may file a Second Level Complaint within forty-five (45) days or may file an external complaint review request within fifteen (15) days. For an Expedited Complaint Decision, a Participant may file a request for an expedited external Complaint review within two (2) business days from the date of receiving the Complaint decision. In some instances, the Participant may also file for a Fair Hearing within one hundred and twenty (120) days from the mail date on the first level complaint decision.

Second Level Complaint Process

The second level Complaint review is also performed at the plan by staff who were not part of the first level Complaint review. The CHC-MCO must provide the

Participant an opportunity to appear before the second level Complaint review committee, must work with the Participant to schedule the hearing at a time when the Participant is available in person or telephonically, and must provide at least fifteen (15) days advance written notice of the review date.

The second level Complaint review committee shall complete its review within forty-five (45) days from the CHC-MCO's receipt of the Participant's second level Complaint.

If a Participant does not agree with the decision of the Second Level Complaint process, they may request an external review by the PA Department of Health or by the PA Insurance Department within fifteen (15) days of receiving the written notice of the second level Complaint decision or within 10 days if seeking continuing benefits pending the outcome of the external review of the Second Level Complaint Decision. Additionally, in some circumstances, a Participant may file for a Fair Hearing. This external review must be completed within thirty (30) days from the mail date on the written notice of the CHC-MCO's second level Complaint decision.

Grievance Requirements

Grievance Process

Participants who want to file a Grievance have sixty (60) days to file the Grievance, from the date they receive the written notice from the CHC-MCO. The Grievance can be filed in writing or orally. A representative with written proof of the Participant's authorization for the representative to be involved and/or act on the Participant's behalf may file instead. If the Participant files a Grievance about a CHC-MCO decision to stop, reduce or change a service/item that the Participant has been receiving within ten (10) days from the mail date on the written notice from the CHC-MCO, the CHC-MCO must continue to provide the disputed service or item at the previously authorized level until the Grievance is resolved. The Participant must be given the reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing. The CHC-MCO must reach out to the Participant to schedule the review at a time convenient to the Participant and must provide at least fifteen (15) days advance written notice of the telephone or video conference review. The CHC-MCO must complete its review of the Grievance as expeditiously as the Participant's health condition

requires, but no more than thirty (30) days from receipt of the Grievance, which may be extended by fourteen (14) days at the request of the Participant.

The CHC-MCO must process the Grievance more quickly if the Participant requests an expedited Grievance and provides a signed written certification from their provider that the Participant's life, health or ability to attain, maintain, or regain maximum function would be placed in jeopardy by following the regular Grievance process with the regular timeframes. An expedited Grievance must be decided within either forty-eight (48) hours of receiving the Provider certification, or seventy-two (72) hours of receiving the Participant's request for an expedited review, whichever is shorter. It must be mailed within two (2) business days.

If the Participant does not agree with the Grievance decision, they may file either a request for external review within fifteen (15) days or may file a request for Fair Hearing within one hundred and twenty (120) days, or they may file both.

External Review of Grievance Decision

External review of a grievance means that an independent entity, a Certified Review Entity (CRE) not connected to the CHC-MCO, will review the CHC-MCO's decision. The CRE must provide a written decision within sixty (60) days of the filing of the request for the external review. The standard of review shall be whether the service/item was Medically Necessary and appropriate under the terms of the CHC-MCO's contract. The external Grievance decision may be appealed by the Participant, the Participant's representative, or the Healthcare Provider to a court of competent jurisdiction within sixty (60) days from the date the Participant receives notice of the external Grievance decision.

Fair Hearing Request

A Participant must file a Complaint or Grievance with the CHC-MCO and receive a decision on the Complaint or Grievance before filing a request for a Fair Hearing. If the CHC-MCO fails to provide written notice of a Complaint or Grievance decision within the time frames specified in this Exhibit, the Member is deemed to have exhausted the Complaint or Grievance process and may request a Fair Hearing. The Participant may file a request for a DHS Fair Hearing within one hundred and twenty (120) days from the mail date on a written coverage determination notice of the CHC-MCO's, which includes the completed, written PCSP, from the mail date on the Complaint or Grievance decision. A Participant who is requesting a Fair Hearing to dispute a decision to stop, reduce or change a service/item that the Participant has been receiving and whose request is hand

delivered or postmarked within ten (10) days from the mail date on the written notice of decision, must continue to be provided the disputed service/item at the previously authorized level until the Fair Hearing is resolved.

Participants will receive notification of their Fair Hearing date by letter at least ten (10) days in advance, or a shorter time if requested by the Participant. The letter will say when and where the hearing will take place. Hearings may be in person or by telephone or video conference. The state Bureau of Hearings and Appeals has ninety (90) days to issue a decision, or sooner if the Participant requests an Expedited Fair Hearing and provides a signed, written certification from the Participant's Provider that the Participant's life, health or ability to attain, maintain or regain maximum function would be placed in jeopardy by following the regular DHS Fair Hearing process. Then, the state Bureau of Hearings and Appeals has three (3) business days to reach a decision.

If a Participant does not agree with the Fair Hearing decision, they may request reconsideration from the Secretary of the Department of Human Services within fifteen (15) days or the Participant may file an appeal in Commonwealth Court within thirty (30) days. The decision notice will include instructions for how to request either of these.

Protections while in Complaint, Grievance and Fair Hearings process

1. Participants cannot be charged for filing a complaint, grievance, or fair hearing.
2. CHC-MCOs must have written rules and policies outlining how their complaint and grievance processes work and must make these available to Participants upon request.
3. The CHC-MCO must maintain written documentation of each Complaint and Grievance and the actions taken by the CHC-MCO.
4. The CHC-MCO must provide Participants with access to all relevant documentation pertaining to the subject of the Complaint or Grievance.
5. The CHC-MCO must provide Participants with assistance in presenting their case at Complaint or Grievance reviews at no cost to the participant.

This Includes:

- Providing qualified sign language interpreters for Participants who are severely hearing impaired.

- Providing information submitted on behalf of the CHC-MCO at the Complaint or Grievance review in an alternative format accessible to the Participant filing the Complaint or Grievance. The alternative format version should be supplied to the Participant at or before the review, so the Participant can discuss and/or refute the content prior to the review.
 - Providing personal assistance to Participants with other physical limitations in copying and presenting documents and other evidence.
6. The CHC-MCO must provide language interpreter services when requested by a Participant, at no cost to the Participant.
 7. The CHC-MCO must offer Participants the assistance of a CHC-MCO staff member throughout the Complaint and Grievance processes at no cost to the participant.
 8. The CHC-MCO must ensure that any location where it will hold in-person reviews is physically accessible for persons with disabilities.
 9. The CHC-MCO must use Pennsylvania's required templates for all notices.
- (Additional protections can be found in Appendix C.)

Other Ways to Voice Concerns

In addition to the standard Grievance and Appeal processes for CHC, Participants may voice concerns about Medicare quality issues using both the Medicare Grievance and Appeal processes and the Medicare quality assurance entity, the Quality Improvement Organization (QIO). In Pennsylvania, Livanta is the Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO). Additionally, appeals about language access and accessibility may be filed with the Office of Civil Rights at the Department of Justice.

Advocacy Note: CHC must comply with applicable Federal civil rights laws and must not discriminate based on race, color, national origin, age, disability, creed, religious affiliation, ancestry, sex, gender, gender identity or expression, or sexual orientation. If CHC has not provided language access or accessible services, or if a consumer believes to have been discriminated in another way based on race, color, national origin, age, disability, or sex, a grievance with Pennsylvania's Bureau of Equal Opportunity may be made in addition to federal resources.

XV. How does CHC Coordinate with Medicare?

CHC does not cover Medicare physical health or behavioral health services. Because so many Participants have Medicare, the CHC-MCOs are required to coordinate with each Participant's choice of Medicare coverage and Medicare providers. The CHC-MCO parent organizations are required to offer Medicare Advantage Dual Eligible Special Needs Plans (D-SNPs). These are Medicare Advantage plans specifically required to work with their members' Medicaid plans. The CHC-MCO may encourage Participants to consider the D-SNP that their parent organization/company offers but Participants always have the choice of whether to join the D-SNP or any other Medicare product.

XVI. Where to Turn for Help

Participants may experience problems with getting what they need. There are many valuable resources that can help Participants with resolving issues. CARIE is always available to provide help or referral. Please see Appendix G for a complete list of Helpful Contacts/Contact Information.

If a Participant wants general information about CHC:

- Beneficiary Support System/Ombudsman
- CARIE
- AAA/Aging Well
- ADRCs

If a Participant wants information about CHC plan options:

- IEB
- Beneficiary Support System/Ombudsman

If a Participant has a problem related to enrollment or eligibility for CHC:

- CARIE (Statewide)
- PHLP (Statewide)
- CLS (Philadelphia only)
- Local Legal Services (Outside Philadelphia)
- IEB

If a Participant wants to change their PCP, service coordinator, or other provider:

- CHC-MCO Service Coordinator (if applicable)
- CHC-MCO Participant Services Toll-Free Call Center

If a Participant does not know how to contact their service coordinator or has questions about coverage:

- CHC-MCO Participant Services Toll-Free Call Center

If a Participant wants to request a service, an increase in service hours, or a change in their Person-Centered Service Plan (PCSP):

- CHC-MCO Service Coordinator (if applicable)
- CHC-MCO Participant Services Toll-Free Call Center

If a Participant wants to appeal a CHC-MCO decision or file a complaint about a CHC-MCO:

- PHLP (Statewide)
- CLS (Philadelphia only)
- Local Legal Services (Outside Philadelphia)

If a Participant is having problems with their nursing facility, assisted living residence, personal care home, or other LTC facility:

- CARIE
- Long-Term Care Ombudsman/AAA

If a Participant has questions about Medicare plan options or Medicare related problems:

- APPRISE
- Quality Improvement Organization
- CARIE
- Medicare

If a Participant Gets Billed:

Whether a Participant has only Medicaid or has both Medicaid and Medicare, they should not be receiving any bills for covered services they received. Sometimes providers bill erroneously because they are not fully aware of all the rules. These should **not** be paid by the Participant. Instead, Participants who receive a bill should contact their CHC-MCO to have the billing issue resolved. If this does

not resolve the issue, the Participant should contact CARIE, APPRISE, PHLP or local legal services.

If a Participant has a complaint about language or disability access:

- Office of Civil Rights at the U.S. Department of Justice
- Pennsylvania Office of Attorney General
- Pennsylvania Bureau of Equal Opportunity
- In Philadelphia, CLS

If a Participant has a problem or a question and does not know where to turn:

- CARIE

Please see Appendix G for a complete list of Helpful Contacts/Contact Information.

Appendices

A – All the Cards a Participant Might Have

B – CHC-MCO Contacts and Links

C – Details of the CHC-MCO Complaint, Grievance, and Fair Hearing Processes

D - Enrollment Notices

E - Denial Notices

F - Grievance and Appeals Notices

G - Helpful Contacts

H – Other Resources

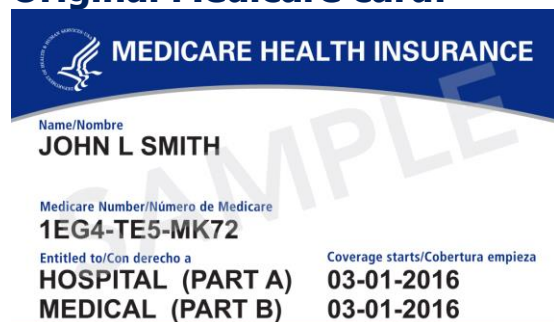
I – Glossary

J – Acronyms

Appendix A: What ID Cards a Participant Might Have

The following are some of the identification cards that a participant may have and need to use to get services:

Original Medicare card:



Medicare beneficiaries who choose a Medicare Advantage plan will also receive an ID card from their insurance company. Consumers who use a Medicare Advantage plan will not need to show their Original Medicare card (image above) but should keep it in a safe place. Consumers with Original Medicare may also have a Medicare Part D card for prescription drug coverage.

Pennsylvania Access cards:



The Pennsylvania Department of Human Services provides ACCESS cards for Medicaid benefits. Recipients who are eligible for medical benefits only will get a yellow ACCESS card. Recipients who receive cash assistance and/or food stamps/SNAP as well as medical services, if eligible, will get a blue and green ACCESS card with the word "ACCESS" printed in yellow letters. Consumers may need to show their ACCESS card to get services such as transportation through the Medical Assistance Transportation Program or may need to show another ID card to get services.


CHC-MCO ID Cards:

Each CHC-MCO will send an ID card to its members. Participants must show this card when seeking healthcare and other services. Here are samples of the cards.

AmeriHealth Caritas/Keystone First CHC ID Card:

	
Participants: Call Participant Services at 1-855-235-5115 (TTY 1-855-235-5112) or visit our website at www.amerhealthcaritaschc.com . Providers: Call 1-800-521-6007. Provider precertification number: 1-800-521-6622 Submit claims to: AmeriHealth Caritas PA CHC Claims P.O. Box 7110 London, KY 40742	ACPCHC dental PCO: Any network dentist For pharmacy benefit information: Participants call: 1-888-987-6696 Pharmacies call: 1-888-674-8720 Submit prescription claims to: <Perform/ACPCHC P.O. Box 516 Essington, PA 19029> Pharmacists: Rx ID is the Participant ID.
www.amerhealthcaritaschc.com	

PA Health & Wellness CHC ID Card:

	IMPORTANT CONTACT INFORMATION Participant: Participant Services: 1-844-626-6813 TDD/TTY: 1-844-349-8916 Nurse Advice Line: 1-844-626-6813 Vision: 1-844-626-6813 Dental: 1-844-626-6813 File a Complaint: 1-844-626-6813 Medical Claims: EDI Payer for Medical Claims 68069 PA Health & Wellness Attn: Claims P.O. Box 5070 Farmington, MO 63640-5050 Providers: Provider Services: 1-844-626-6813 IVR Eligibility Inquiry - Prior Auth: 1-844-626-6813 Vision: 1-844-788-4071 Dental: 1-844-524-8255 Envolve Pharmacy Solutions Pharmacy Help Desk: 1-888-321-3120	PA Health & Wellness Address: 300 Corporate Center Drive Camp Hill, PA 17011 EDI/EFT/ERA please visit Provider Resources at PAHealthWellness.com If you have an emergency, call 911 or go to the nearest emergency room (ER). Emergency services by a provider not in the PA Health & Wellness network will be covered without prior approval. PAHealthWellness.com
Name: <First Last> DOB: <00/00/0000> MEDICAID ID#: <XXXXXXXXXXXX> PCP: <First Last> PCP Phone: <XX-XXX-XXXX> PCP Address: <Street <Name> <City, State ZIP>	RXBIN: 004336 RXPCN: MCAIDADV RXGRP: RX5455 Effective Date: <mm/dd/yyyy>	

UPMC Community HealthChoices ID Card:

	
Health Plan (80840): 610207001 Primary ID: 0000000000 Secondary ID: 0000000000 SUE CARDHOLDER PCP: CHESTNUT RIDGE FAMILY MEDICINE Phone: (814) 839-4152 Rx BIN: 000000 Rx PCN: xx Rx GRP: xxxxx  CMS: H4279-001	Member Services: 1-844-833-0523 TTY: 1-866-407-8762 Web: www.upmchealthplan.com Behavioral Health: 1-888-251-0083 TTY: 1-877-877-3580 UPMC MyHealth 24/7 Nurse Line: 1-866-918-1591 Claims: UPMC Health Plan, PO Box 0000, Pgh, PA 15230 Provider Services: 1-844-860-9303 Pharmacist Help Desk: 1-800-000-0000 Rx processed by Express Scripts, Inc. xx Issued: 00/00/0000

Participants should show their CHC-MCO card, Medicare or Medicare Advantage card, and ACCESS card to providers such as when visiting a doctor's office.

Each CHC-MCO also offers a Medicare Advantage Special Needs Plan (D-SNP) for CHC Participants who are also Medicare beneficiaries. If a Participant opts for a CHC-MCO D-SNP plan, they will only need to show this one card to Medicare providers but must be sure to use the CHC-MCO's provider network. A Participant will still need to show their ACCESS card for certain Medicaid services.

Appendix B: CHC-MCO Contacts and Links

AmeriHealth Caritas/Keystone First Pennsylvania

1-855-235-5115 (TTY: 1-855-235-5112)

www.amerihealthcaritaschc.com

Pennsylvania Health & Wellness

1-844-626-6813 (TTY: 1-844-349-8916)

www.PAHealthWellness.com

UPMC Community HealthChoices

1-844-833-0523 (TTY: 1-866-407-8762)

www.upmchealthplan.com/chc

Appendix C: CHC-MCO Complaint, Grievance, and Fair Hearing Processes

From CHC Draft Agreement, Exhibit G

COMPLAINT, GRIEVANCE, AND DHS FAIR HEARING PROCESSES

A. General Requirements

1. The CHC-MCO must obtain the Department's prior written approval of its Complaint, Grievance, and Fair Hearing policies and procedures.
2. The CHC-MCO must have written policies and procedures for registering, responding to, and resolving Complaints and Grievances as they relate to the MA population and must make these policies and procedures available to Participants upon request.
3. The CHC-MCO must maintain an accurate written record of each Complaint and Grievance and the actions taken by the CHC-MCO to resolve each Complaint and Grievance. The record must include at least the following:
 - a. The name of the Participant on whose behalf the Complaint or Grievance was filed;
 - b. The date the Complaint or Grievance was received;
 - c. A description of the reason for the Complaint or Grievance;
 - d. The date of each review or review meeting;
 - e. The date of resolution of the Complaint or Grievance and how the Complaint or Grievance was resolved; and
 - f. A Copy of any documents or records reviewed.The CHC-MCO must submit of a log of all Complaint and Grievance decisions in a format specified by the Department and must include review of the Complaint and Grievance processes in its QM and UM programs.
4. The CHC-MCO must submit of a log of all Complaint and Grievance decisions in a format specified by the Department and must include review of the Complaint and Grievance processes in its QM and UM programs.
5. The CHC-MCO must have a data system to process, track, and trend all Complaints and Grievances.
6. The CHC-MCO must designate and train sufficient staff to be responsible for receiving, processing, and responding to Participant

- Complaints and Grievances in accordance with the requirements specified in this Exhibit.
7. CHC-MCO staff performing Complaint and Grievance reviews must have the necessary orientation, clinical training, and experience to make an informed and impartial determination regarding issues assigned to them.
 8. The CHC-MCO must provide information about the Complaint and Grievance process to all Providers and subcontractors when the CHC-MCO enters into a contract or agreement with the Provider or subcontractor.
 9. The CHC-MCO may not use the timeframes or procedures of the Complaint or Grievance process to avoid the medical decision process or to discourage or prevent a Participant from receiving Medically Necessary care in a timely manner.
 10. The CHC-MCO must require that anyone who participates in making the decision on a Complaint or Grievance was not involved in and is not a subordinate of an individual who was involved in any previous level of review or decision-making on the issue that is the subject of the Complaint or Grievance.
 11. The CHC-MCO may not charge Participants a fee for filing a Complaint or a Grievance.
 12. The CHC-MCO must allow the Participant and the Participant's representative to have access to all relevant documentation pertaining to the subject of the Complaint or Grievance free of charge and sufficiently in advance of the time frame for resolution of the Complaint or Grievance outlined in this Exhibit.
 13. The CHC-MCO must maintain the following information in the Participant's case file:
 - a. Medical records;
 - b. Any documents or records relied upon or generated by the CHC-MCO in connection with the Complaint or Grievance, including any Medical Necessity criteria used to make a decision or information on coverage limits relied upon to make a decision; and
 - c. Any new or additional evidence considered, relied upon, or generated by the CHC-MCO in connection with the Complaint or Grievance.
 14. The CHC-MCO must provide language interpreter services at no cost when requested by a Participant.
 15. The CHC-MCO must accept Complaints and Grievances from individuals with disabilities which are in alternative formats including: TTY/TDD for

- telephone inquiries and Complaints and Grievances from Participants who are deaf or hearing impaired; Braille; tape; computer disk; and other commonly accepted alternative forms of communication. The CHC-MCO must make its employees who receive telephone Complaints and Grievances aware of the speech limitations of Participants with disabilities, so they treat these individuals with patience, understanding, and respect.
16. The CHC-MCO must provide Participants with disabilities assistance in presenting their case at Complaint or Grievance reviews at no cost to the Participant. This includes but is not limited to:
 - a. Providing qualified sign language interpreters for Participants who are deaf or hearing impaired;
 - b. Providing information submitted on behalf of the CHC-MCO at the Complaint or Grievance review in an alternative format accessible to the Participant filing the Complaint or Grievance. The alternative format version must be supplied to the Participant at or before the review, so the Participant can discuss and/or refute the content during the review; and
 - c. Providing personal assistance to a Participant filing the Complaint or Grievance who has other physical limitations in copying and presenting documents and other evidence.
 17. The CHC-MCO must offer Participants the assistance of a CHC-MCO staff member throughout the Complaint and Grievance processes at no cost to the Participant.
 18. The CHC-MCO must provide Participants with a toll-free number to file a Complaint or Grievance, request information about the Complaint or Grievance process, and ask any questions the Participant may have about the status of a Complaint or a Grievance.
 19. The CHC-MCO must, at a minimum, hold in-person reviews of Complaints and Grievances at one location within each of its zones of operation. If a Participant requests an in-person review, the CHC-MCO must notify the Participant of the location of the review and who will be present at the review, using the template specified by the Department.
 20. The CHC-MCO must ensure that any location where it will hold in-person reviews is physically accessible for persons with disabilities.
 21. The CHC-MCO must notify the Participant when the CHC-MCO fails to decide a first level Complaint or a Grievance within the time frames specified in this Exhibit, using the template specified by the Department.

- The CHC-MCO must mail this notice to the Participant one (1) day following the date the decision was to be made (day 31).
22. The CHC-MCO must notify the Participant when it denies payment after a service or item has been delivered because the service or item was provided without authorization by a provider not enrolled in the MA Program, using the template specified by the Department. The CHC-MCO must mail this notice to the Participant on the day the decision is made to deny payment.
 23. The CHC-MCO must notify the Participant when it denies payment after a service or item has been delivered because the service or item provided is not a Covered Service for the Participant, using the template specified by the Department. The CHC-MCO must mail this notice to the Participant on the day the decision is made to deny payment.
 24. The CHC-MCO must notify the Participant when it denies payment after a service or item has been delivered because the CHC-MCO determined that the service or item was not Medically Necessary, using the template specified by the Department. The CHC-MCO must mail this notice to the Participant on the day the decision is made to deny payment.
 25. The CHC-MCO must use all templates specified by the Department, which are available on the CHC Intranet site.

B. Complaint Process

Complaint: A dispute or objection regarding a participating Health Care Provider or the coverage, operations, or management of a CHC-MCO, which has not been resolved by the CHC-MCO and has been filed with the CHC-MCO or with DOH or PID, including but not limited to:

- a denial because the requested service or item is not a Covered Service;
- the failure of the CHC-MCO to provide a service or item in a timely manner, as defined by the Department;
- the failure of the CHC-MCO to decide a Complaint or Grievance within the specified time frames;
- a denial of payment by the CHC-MCO after a service or item has been delivered because the service or item was provided without authorization by a provider not enrolled in the MA Program;
- a denial of payment by the CHC-MCO after a 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.
- The term does not include a Grievance.

1. First Level Complaint Process

- a. A CHC-MCO must permit a Participant or Participant's representative, which may include the Participant's Provider, with proof of the Participant's written authorization for the representative to be involved and/or act on the Participant's behalf, to file a first level Complaint either in writing or orally. The CHC-MCO must commit oral requests to writing if not confirmed in writing by the Participant and must provide the written Complaint to the Participant or Participant's representative for signature. The signature may be obtained at any point in the process, and failure to obtain a signed Complaint may not delay the Complaint process.
- b. If the first level Complaint disputes one of the following, the Participant must file a Complaint within sixty (60) days from the date of the incident complained of or the date the Participant receives written notice of a decision:
 - i. a denial because the service or item is not a Covered Service;
 - ii. the failure of the CHC-MCO to provide a service or item in a timely manner, as defined by the Department;
 - iii. the failure of the CHC-MCO to decide a Complaint or Grievance within the specified time frames;
 - iv. 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 MA Program;
 - v. 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
 - vi. 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.
- c. A Participant who files a first level Complaint to dispute a decision to discontinue, reduce, or change a service or item that the Participant has been receiving on the basis that the service or item is not a

- Covered Service must continue to receive the disputed service or item at the previously authorized level pending resolution of the first level Complaint, if the first level Complaint is made verbally, hand delivered, or postmarked within ten (10) days from the mail date on the written notice of decision.
- d. Upon receipt of the Complaint, the CHC-MCO must send the Participant and Participant's representative, if the Participant has designated one in writing, a first level Complaint acknowledgment letter, using the template specified by the Department.
 - e. The first level Complaint review for Complaints **not involving a clinical issue** must be conducted by a first level Complaint review committee, which must include one or more employees of the CHC-MCO who were not involved in and are not the subordinates of an individual involved in any previous level of review or decision-making on the issue that is the subject of the Complaint.
 - f. The first level Complaint review for Complaints **involving a clinical issue** must be conducted by a first level Complaint review committee, which must include one or more employees of the CHC-MCO who were not involved in and are not the subordinates of an individual involved in any previous level of review or decision-making on the issue that is the subject of the Complaint. The first level Complaint review committee must include a licensed physician in the same or similar specialty that typically manages or consults on the service or item in question. Other appropriate providers may participate in the review, but the licensed physician must decide the first level Complaint.
 - g. A committee member who does not personally attend the first level Complaint review meeting may not be part of the decision-making process unless that member actively participates in the review by telephone or videoconference and has the opportunity to review all information presented during the review.
 - h. The CHC-MCO must afford the Participant a reasonable opportunity to present evidence and testimony and make legal and factual arguments, in person as well as in writing.
 - i. The CHC-MCO must give the Participant at least seven (7) days advance written notice of the first level Complaint review date, using the template specified by the Department. The CHC-MCO must be flexible when scheduling the review to facilitate the Participant's attendance. If the Participant cannot appear in person at the review,

- the CHC-MCO must provide an opportunity for the Participant to communicate with the first level Complaint review committee by telephone or videoconference.
- j. The Participant may elect not to attend the first level Complaint review meeting, but the meeting must be conducted with the same protocols as if the Participant was present.
 - k. If a Participant requests an in-person first level Complaint review, at a minimum, a member of the first level Complaint review committee must be physically present at the location where the first level Complaint review is held and the other members of the first level Complaint review committee must participate in the review through the use of videoconferencing.
 - l. The decision of the first level Complaint review committee must take into account all comments, documents, records, and other information submitted by the Participant or the Participant's representative without regard to whether such information was submitted or considered in the initial determination of the issue.
 - m. The first level Complaint review committee must complete its review of the Complaint as expeditiously as the Participant's health condition requires.
 - n. The first level Complaint review committee must prepare a summary of the issues presented and decisions made, which must be maintained as part of the Complaint record.
 - o. The CHC-MCO must send a written notice of the first level Complaint decision, using the template specified by the Department, to the Participant, Participant's representative, if the Participant has designated one, service Provider and prescribing Provider, if applicable, within thirty (30) days from the date of receipt of the Complaint unless the time frame for deciding the Complaint has been extended by up to fourteen (14) days at the request of the Participant.
 - p. If the Complaint disputes one of the following, the Participant may file a request for a Fair Hearing, a request for an external review, or both a request for a Fair Hearing and a request for an external review:
 - i. a denial because that the service or item is not a Covered Service;
 - ii. the failure of the CHC-MCO to provide a service or item in a timely manner, as defined by the Department;

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

The Participant or Participant's representative may file a request for a Fair Hearing within one hundred and twenty (120) days from the mail date on the written notice of the CHC-MCO's first level Complaint decision.

The Participant or Participant's representative, which may include the Participant's Provider, with proof of the Participant's written authorization for the representative to be involved and/or act on the Participant's behalf, may file a request for an external review in writing with either DOH or PID within fifteen (15) days from the date the Participant receives written notice of the CHC- MCO's first level Complaint decision.

For all other Complaints, the Participant or Participant's representative, which may include the Participant's Provider, with proof of the Participant's written authorization for the representative to be involved and/or act on the Participant's behalf, may file a second level Complaint either in writing or orally within forty- five (45) days from the date the Participant receives written notice of the CHC- MCO's first level Complaint decision.

2. Second Level Complaint Process

- a. A CHC-MCO must permit a Member or Member's representative, which may include the Member's Provider, with proof of the Member's written authorization for the representative to be involved and/or act on the Member's behalf, to file a second level Complaint either in writing or orally for any Complaint for which a Fair Hearing and external review is not available.
- b. Upon receipt of the second level Complaint, the CHC-MCO must send the Participant and Participant's representative, if the Participant has designated one in writing, a second level Complaint

- acknowledgment letter, using the template specified by the Department.
- c. The second level Complaint review for Complaints **not involving a clinical issue** must be performed by a second level Complaint review committee made up of three (3) or more individuals who were not involved in and are not the subordinates of an individual involved in any previous level of review or decision-making on the issue that is the subject of the Complaint.
 - d. The second level Complaint review for Complaints **involving a clinical issue** must be conducted by a second level Complaint review committee made up of three (3) or more individuals who were not involved in and are not the subordinates of an individual involved in any previous level of review or decision-making on the issue that is the subject of the Complaint. The second level Complaint review committee must include a licensed physician in the same or similar specialty that typically manages or consults on the service or item in question. Other appropriate providers may participate in the review, but the licensed physician must decide the second level Complaint.
 - e. At least one-third of the second level Complaint review committee members may not be employees of the CHC-MCO or a related subsidiary or Affiliate.
 - f. A committee member who does not personally attend the second level Complaint review may not be part of the decision-making process unless that member actively participates in the review by telephone or videoconference and has the opportunity to review all information introduced during the review.
 - g. The CHC-MCO must afford the Participant a reasonable opportunity to present evidence and testimony and make legal and factual arguments, in person as well as in writing.
 - h. The CHC-MCO must give the Participant at least fifteen (15) days advance written notice of the second level review date, using the template specified by the Department. If the Participant cannot appear in person at the review, the CHC-MCO must provide an opportunity for the Participant to communicate with the second level Complaint review committee by telephone or videoconference. The CHC-MCO must be flexible when scheduling the review to facilitate the Member's attendance.

- i. The Participant may elect not to attend the second level Complaint review meeting, but the meeting must be conducted with the same protocols as if the Participant was present.
- j. If a Participant requests an in-person second level Complaint review, at a minimum, a member of the second level Complaint review committee must be physically present at the location where the second level Complaint review is held and the other members of the second level Complaint review committee must participate in the review through the use of videoconferencing.
- k. The decision of the second level Complaint review committee must take into account all comments, documents, records, and other information submitted by the Participant or the Participant's representative without regard to whether such information was submitted or considered previously. The decision of the second level Complaint review committee must be based solely on the information presented at the review.
- l. The testimony taken by the second level Complaint review committee (including the Participant's comments) must be either tape-recorded and a summary prepared **or** transcribed verbatim and a summary prepared and maintained as part of the Complaint record.
- m. The second level Complaint review committee must complete its review of the second level Complaint as expeditiously as the Participant's health condition requires.
- n. The CHC-MCO must send a written notice of the second level Complaint decision, using the template specified by the Department, to the Participant, Participant's representative, if the Participant has designated one in writing, service Provider, and prescribing Provider, if applicable, within forty-five (45) days from the date of receipt of the second level Complaint.
- o. The Participant or the Participant's representative, which may include the Participant's Provider, with proof of the Participant's written authorization of the representative to be involved and/or act of the Participant's behalf, may file in writing a request for an external review of the second level Complaint decision with either DOH or PID within fifteen (15) days from the date the Member receives the written notice of the CHC-MCO's second level Complaint decision.

3. External Complaint Process

- a. If a Participant files a request for an external review of a Complaint decision that disputes a decision to discontinue, reduce, or change a service or item that the Participant has been receiving on the basis that the service or item is not a Covered Service, the Participant must continue to receive the disputed service or item at the previously authorized level pending resolution of the external review, if the request for external review is hand-delivered or postmarked within ten (10) days from the mail date on the written notice of the CHC-MCO's first or second level Complaint decision.
- b. Upon the request of either DOH or PID, the CHC-MCO must transmit all records from the CHC-MCO's Complaint review to the requesting department within thirty (30) days from the request in the manner prescribed by that department. The Participant, the Provider, or the CHC-MCO may submit additional materials related to the Complaint.
- c. DOH and PID will determine the appropriate agency for the review.

4. Expedited Complaint Process

- a. The CHC-MCO must conduct expedited review of a Complaint if the CHC-MCO determines that the Participant's life, physical or mental health, or ability to attain, maintain, or regain maximum function would be placed in jeopardy by following the regular Complaint process or if a Participant or Participant's representative, with proof of the Participant's written authorization for the representative to be involved and/or act on the Participant's behalf, provides the CHC-MCO with a certification from the Participant's Provider that the Participant's life, physical or mental health, or ability to attain, maintain, or regain maximum function would be placed in jeopardy by following the regular Complaint process. The certification must include the Provider's signature.
- b. A request for an expedited review of a Complaint may be filed in writing, by fax, orally, or by email
- c. Upon receipt of an oral or written request for expedited review, the CHC-MCO must inform the Participant of the right to present evidence and testimony and make legal and factual arguments in person as well as in writing and of the limited time available to do so.
- d. If the Provider certification is not included with the request for an expedited review and the CHC-MCO cannot determine based on the

- information provided that the Participant's life, physical or mental health, or ability to attain, maintain, or regain maximum function would be placed in jeopardy by following the regular Complaint process, the CHC-MCO must inform the Participant that the Provider must submit a certification as to the reasons why the expedited review is needed. The CHC-MCO must make a reasonable effort to obtain the certification from the Provider. If the Provider certification is not received within seventy-two (72) hours of the Participant's request for expedited review, the CHC-MCO must decide the Complaint within the standard time frames as set forth in this Exhibit. The CHC-MCO must make a reasonable effort to give the Participant prompt oral notice that the Complaint is to be decided within the standard time frame and send a written notice within two (2) business days of the decision to deny expedited review, using the template specified by the Department.
- e. A Participant who files a request for expedited review of a Complaint to dispute a decision to discontinue, reduce, or change a service or item that the Participant has been receiving on the basis that the service or item is not a Covered Service must continue to receive the disputed service or item at the previously authorized level pending resolution of the Complaint, if the request for expedited review is made orally, hand delivered, faxed, emailed, or postmarked within ten (10) days from the mail date on the written notice of decision.
 - f. Expedited review of a Complaint must be conducted by a Complaint review committee that includes a licensed physician in the same or similar specialty that typically manages or consults on the service or item in question. Other appropriate providers may participate in the review, but the licensed physician must decide the Complaint. The members of the expedited Complaint review committee may not have been involved in and not be the subordinates of an individual involved in any previous level of review or decision-making on the issue that is the subject of the Complaint.
 - g. The CHC-MCO must prepare a summary of the issues presented and decisions made, which must be maintained as part of the expedited Complaint record.
 - h. The CHC-MCO must issue the decision resulting from the expedited review in person or by phone to the Participant, the Participant's representative, if the Participant has designated one in writing, service Provider and prescribing Provider, if applicable, within either

- forty-eight (48) hours of receiving the Provider certification or seventy-two (72) hours of receiving the Participant's request for an expedited review, whichever is shorter. In addition, the CHC- MCO must mail written notice of the decision to the Participant, the Participant's representative, if the Participant has designated one in writing, the Participant's service Provider, and prescribing Provider, if applicable, within two (2) business days of the decision, using the template specified by the Department.
- i. The Participant or the Participant's representative may file a request for a Fair Hearing within one hundred and twenty (120) days from the mail date on the written notice of the CHC-MCO's expedited Complaint decision.
 - j. The Participant, or the Participant's representative, which may include the Participant's Provider, with proof of the Participant's written authorization for the representative to be involved and/or act on the Participant's behalf, may file a request for an expedited external Complaint review with the CHC-MCO within two (2) business days from the date the Participant receives the CHC- MCO's expedited Complaint decision. A Participant who files a request for an expedited Complaint review that disputes a decision to discontinue, reduce, or change a service or item that the Participant has been receiving must continue to receive the disputed service or item at the previously authorized level pending resolution of the request for expedited Complaint review.
 - k. A request for an expedited external Complaint review may be filed in writing, by fax, orally, or by email.
 - l. The CHC-MCO must follow DOH guidelines relating to submission of requests for expedited external Complaint reviews.
 - m. The CHC-MCO may not take punitive action against a Provider who requests expedited resolution of a Complaint or supports a Participant's request for expedited review of a Complaint.

C. Grievance Requirements

Grievance: A request to have a CHC-MCO or utilization review entity reconsider a decision concerning the Medical Necessity and appropriateness of a Covered Service. A Grievance may be filed regarding a CHC-MCO's decision to:

- deny, in whole or in part, payment for a service or item;

- deny or issue a limited authorization of a requested service or item, including a determination based on the type or level of service or item;
- reduce, suspend, or terminate a previously authorized service or item;
- deny the requested service or item but approve an alternative service or item; and,
- deny a request for a Benefit Limit Exception (BLE).

The term does not include a Complaint.

1. Grievance Process

- a. A CHC-MCO must permit a Participant or Participant's representative, which may include the Participant's Provider, with proof of the Participant's written authorization for the representative to be involved and/or act on the Participant's behalf, to file a Grievance either in writing or orally. The CHC- MCO must commit oral requests to writing if not confirmed in writing by the Participant and must provide the written Grievance to the Participant or the Participant's representative for signature. The signature may be obtained at any point in the process, and the failure to obtain a signed Grievance may not delay the Grievance process.
- b. A Participant must file a Grievance within sixty (60) days from the date the Participant receives written notice of decision.
- c. A Participant who files a Grievance to dispute a decision to discontinue, reduce, or change a service or item that the Participant has been receiving must continue to receive the disputed service or item at the previously authorized level pending resolution of the Grievance, if the request for review of the Grievance is made orally, hand delivered, or postmarked within ten (10) days from the mail date on the written notice of decision.
- d. Upon receipt of the Grievance, the CHC-MCO must send the Participant and Participant's representative, if the Participant has designated one in writing, a Grievance acknowledgment letter, using the template specified by the Department.
- e. A Participant who consents to the filing of a Grievance by a Provider may not file a separate Grievance. The Participant may rescind consent throughout the process upon written notice to the CHC-MCO and the Provider.
- f. In order for the Provider to represent the Participant in the conduct of a Grievance, the Provider must obtain the written consent of the Participant and submit the written consent with the Grievance. A

Provider may obtain the Participant's written permission at the time of treatment. The CHC-MCO must assure that a Provider does NOT require a Participant to sign a document authorizing the Provider to file a Grievance as a condition of treatment. The written consent must include:

- i. The name and address of the Participant, the Participant's date of birth and identification number;
 - ii. If the Participant is a minor, or is legally incompetent, the name, address, and relationship to the Participant of the person who signed the consent;
 - iii. The name, address, and CHC-MCO identification number of the Provider to whom the Participant is providing consent;
 - iv. The name and address of the CHC-MCO to which the Grievance will be submitted;
 - v. An explanation of the specific service or item which was provided or denied to the Participant to which the consent will apply;
 - vi. The following statement: "The Participant or the Participant's representative may not submit a Grievance concerning the service or item listed in this consent form unless the Participant or the Participant's representative rescinds consent in writing. The Participant or the Participant's representative has the right to rescind consent at any time during the Grievance process.";
 - vii. The following statement: "The consent of the Participant or the Participant's representative shall be automatically rescinded if the Provider fails to file a Grievance or fails to continue to prosecute the Grievance through the review process.";
 - viii. The following statement: "The Participant or the Participant's representative, if the Participant is a minor or is legally incompetent, has read, or has been read, this consent form, and has had it explained to their satisfaction. The Participant or the Participant's representative understands the information in the Participant's consent form."; and
 - ix. The dated signature of the Participant, or the Participant's representative, and the dated signature of a witness.
- g. The Grievance review must be conducted by a Grievance review committee made up of three (3) or more individuals who were not

- involved in and are not the subordinates of an individual involved in any previous level of review or decision-making on the issue that is the subject of the Grievance.
- h. At least one-third of the Grievance review committee may not be employees of the CHC-MCO or a related subsidiary or Affiliate.
 - i. The Grievance review committee must include a licensed physician in the same or similar specialty that typically manages or consults on the service or item in question. Other appropriate providers may participate in the review, but the licensed physician must decide the Grievance.
 - j. A committee member who does not personally attend the Grievance review may not be part of the decision-making process unless that member actively participates in the review by telephone or videoconference and has the opportunity to review all information introduced during the review.
 - k. The CHC-MCO must afford the Participant a reasonable opportunity to present evidence and testimony and make legal and factual arguments, in person as well as in writing.
 - l. The CHC-MCO must give the Participant at least fifteen (15) days advance written notice of the review date, using the template specified by the Department. The CHC-MCO must be flexible when scheduling the review to facilitate the Participant's attendance. If the Participant cannot appear in person at the review, the CHC-MCO must provide an opportunity for the Participant to communicate with the Grievance review committee by telephone or videoconference.
 - m. The Participant may elect not to attend the Grievance review meeting, but the meeting must be conducted with the same protocols as if the Participant was present.
 - n. If a Participant requests an in-person Grievance review, at a minimum, a member of the Grievance review committee must be physically present at the location where the Grievance review is held, and the other members of the Grievance review committee must participate in the review through the use of videoconferencing.
 - o. The decision of the Grievance review committee must take into account all comments, documents, records, and other information submitted by the Participant or the Participant's representative without regard to whether such information was submitted or considered in the initial determination of the issue. The decision of

- the Grievance review committee must be based solely on the information presented at the review.
- p. The testimony taken by the Grievance review committee (including the Participant's comments) must be either tape-recorded and a summary prepared or transcribed verbatim and a summary prepared and maintained as part of the Grievance record.
 - q. The Grievance review committee must complete its review of the Grievance as expeditiously as the Participant's health condition requires.
 - r. The CHC-MCO must send a written notice of the Grievance decision, using the template specified by the Department, to the Participant, Participant's representative, if the Participant has designated one in writing, service Provider and prescribing Provider, if applicable, within thirty (30) days from the date the CHC-MCO received the Grievance, unless the time frame for deciding the Grievance has been extended by up to fourteen (14) days at the request of the Participant.
 - s. The Participant may file a request for a Fair Hearing, a request for an external review, or both a request for a Fair Hearing and a request for an external review.

The Participant or Participant's representative may file a request for a Fair Hearing within one hundred and twenty (120) days from the mail date on the written notice of the CHC-MCO's Grievance decision.

The Participant or Participant's representative, which may include the Participant's Provider, with proof of the Participant's written authorization for a representative to be involved and/or act on the Participant's behalf, may file a request with the CHC-MCO for an external review of a Grievance decision by a certified review entity (CRE) appointed by DOH. The request must be filed in writing or orally within fifteen (15) days from the date the Participant receives the written notice of the CHC-MCO's Grievance decision.

2. External Grievance Process:

- a. The CHC-MCO must process all requests for external Grievance review. The CHC-MCO must follow the protocols established by DOH in meeting all time frames and requirements necessary in

- coordinating the request and notification of the decision to the Participant, Participant's representative, if the Participant has designated one in writing, service Provider, and prescribing Provider.
- b. A Participant who files a request for an external Grievance review that disputes a decision to discontinue, reduce, or change a service or item that the Participant has been receiving must continue to receive the disputed service or item at the previously authorized level pending resolution of the external Grievance review, if the request for external Grievance review is made orally, hand delivered, or postmarked within ten (10) days from the mail date on the written notice of the CHC-MCO's Grievance decision.
 - c. Within five (5) business days of receipt of the request for an external Grievance review, the CHC-MCO must notify the Participant, the Participant's representative, if the Participant has designated one in writing, the Provider, if the Provider filed the request for the external Grievance, and DOH that the request for external Grievance review has been filed.
 - d. The external Grievance review must be conducted by a CRE not affiliated with the CHC-MCO.
 - e. Within two (2) business days from receipt of the request for an external Grievance review, DOH will randomly assign a CRE to conduct the review and notify the CHC-MCO and assigned CRE of the assignment.
 - f. If DOH fails to select a CRE within two (2) business days from receipt of a request for an external Grievance review, the CHC-MCO may designate a CRE to conduct a review from the list of CREs approved by DOH. The CHC-MCO may not select a CRE that has a current contract or is negotiating a contract with the CHC-MCO or its Affiliates or is otherwise affiliated with the CHC-MCO or its Affiliates.
 - g. The CHC-MCO must forward all documentation regarding the Grievance decision, including all supporting information, a summary of applicable issues, and the basis and clinical rationale for the Grievance decision, to the CRE conducting the external Grievance review. The CHC-MCO must transmit this information within fifteen (15) days from receipt of the Participant's request for an external Grievance review.
 - h. Within fifteen (15) days from receipt of the request for an external Grievance review by the CHC-MCO, the Participant or the Participant's representative, or the Participant's Provider, may supply

- additional information to the CRE conducting the external Grievance review for consideration. Copies must also be provided at the same time to the CHC-MCO so that the CHC-MCO has an opportunity to consider the additional information.
- i. Within sixty (60) days from the filing of the request for the external Grievance review, the CRE conducting the external Grievance review must issue a written decision to the CHC-MCO, the Participant, the Participant's representative, and the Provider (if the Provider filed the Grievance with the Participant's consent), that includes the basis and clinical rationale for the decision. The standard of review must be whether the service or item is Medically Necessary and appropriate under the terms of this Agreement.
 - j. The external Grievance decision may be appealed by the Participant, the Participant's representative, or the Provider to a court of competent jurisdiction within sixty (60) days from the date the Participant receives notice of the external Grievance decision.

2. Expedited Grievance Process:

- a. The CHC-MCO must conduct expedited review of a Grievance if the CHC- MCO determines that the Participant's life, physical or mental health, or ability to attain, maintain, or regain maximum function would be placed in jeopardy by following the regular Grievance process or if a Participant or Participant representative, with proof of the Participant's written authorization for a representative to be involved and/or act on the Participant's behalf, provides the CHC-MCO with a certification from the Participant's Provider that the Participant's life, physical or mental health, or ability to attain, maintain, or regain maximum function would be placed in jeopardy by following the regular Grievance process. The certification must include the Provider's signature.
- b. A request for expedited review of a Grievance may be filed either in writing, by fax, by email, or orally.
- c. The expedited review process is bound by the same rules and procedures as the Grievance review process with the exception of time frames, which are modified as specified in this section.
- d. Upon receipt of an oral or written request for expedited review, the CHC-MCO must inform the Participant of the right to present evidence, testimony, make legal and factual arguments in person as well as in writing and of the limited time available to do so.

- e. If the Provider certification is not included with the request for an expedited review and the CHC-MCO cannot determine based on the information provided that the Participant's life, physical or mental health, or ability to attain, maintain, or regain maximum function would be placed in jeopardy by following the regular Grievance process, the CHC-MCO must inform the Participant that the Provider must submit a certification as to the reasons why the expedited review is needed. The CHC-MCO must make a reasonable effort to obtain the certification from the Provider. If the Provider certification is not received within seventy-two (72) hours of the Participant's request for expedited review, the CHC-MCO must decide the Grievance within the standard time frames as set forth in this Exhibit. The CHC-MCO must make a reasonable effort to give the Participant prompt oral notice that the Grievance is to be decided within the standard time frame and send a written notice within two (2) business days of the decision to deny expedited review, using the template specified by the Department.
- f. A Participant who files a request for expedited review of a Grievance to dispute a decision to discontinue, reduce or change a service or item that the Member has been receiving must continue to receive the disputed service or item at the previously authorized level pending resolution of the Grievance, if the request for expedited review of a Grievance is made verbally, hand delivered, or postmarked within ten (10) days from the mail date on the written notice of decision.
- g. Expedited review of a Grievance must be conducted by a Grievance review committee made up of three (3) or more individuals who were not involved in and are not the subordinates of an individual involved in any previous level of review or decision-making on the issue that is the subject of the Grievance.
- h. At least one-third of the expedited Grievance review committee may not be employees of the CHC-MCO or a related subsidiary or Affiliate.
- i. The expedited Grievance review committee must include a licensed physician in the same or similar specialty that typically manages or consults on the service or item in question. Other appropriate providers may participate in the review, but the licensed physician must decide the Grievance.

- j. The CHC-MCO must prepare a summary of the issues presented and decisions made, which must be maintained as part of the expedited Grievance record.
- k. The CHC-MCO must issue the decision resulting from the expedited review in person or by phone to the Participant, the Participant's representative, if the Participant has designated one, and the Participant's Provider within either forty-eight (48) hours of receiving the Provider certification or seventy-two (72) hours of receiving the Participant's request for an expedited review, whichever is shorter. In addition, the CHC-MCO must mail written notice of the decision to the Participant, the Participant's representative, if the Participant has designated one, and the Participant's Provider within two (2) business days of the decision, using the template specified by the Department.
- l. The Participant or the Participant's representative may file a request for a Fair Hearing within one hundred and twenty (120) days from the mail date on the written notice of the CHC-MCO's expedited Grievance decision. The Participant, or Participant's representative, which may include the Participant's Provider, with proof of the Participant's written authorization for the representative to be involved and/or act on the Participant's behalf, may file a request for an expedited external Grievance review with the CHC-MCO within two (2) business days from the date the Participant receives the CHC-MCO's expedited Grievance decision. A Participant who files a request for an expedited external Grievance review to dispute a decision to discontinue, reduce, or change a service or item that the Participant has been receiving must continue to receive the disputed service or item at the previously authorized level pending resolution of the request for expedited Grievance review.
- m. A request for an expedited external Grievance review may be filed in writing, by fax, orally, or by email.
- n. The CHC-MCO must follow DOH guidelines relating to submission of requests for expedited external reviews.
- o. The CHC-MCO may not take punitive action against a Provider who requests expedited resolution of a Grievance or supports a Participant's request for expedited review of a Grievance.

D. Department's Fair Hearing Requirements

Fair Hearing: A hearing conducted by the Department's Bureau of Hearings and Appeals (BHA) or a Department designee.

1. Fair Hearing Process

- a. A Participant must file a Complaint or Grievance with the CHC-MCO and receive a decision on the Complaint or Grievance before filing a request for a Fair Hearing. If the CHC-MCO fails to provide written notice of a Complaint or Grievance decision within the time frames specified in this Exhibit, the Member is deemed to have exhausted the Complaint or Grievance process and may request a Fair Hearing.
- b. The Participant or the Participant's representative may request a Fair Hearing within one hundred and twenty (120) days from the mail date on the written notice of the CHC-MCO's first level Complaint decision or Grievance decision for any of the following:
 - i. the denial, in whole or part, of payment for a requested service or item based on lack of Medical Necessity;
 - ii. the denial of a requested service or item because the service or item is not a Covered Service;
 - iii. the reduction, suspension, or termination of a previously authorized service or item;
 - iv. the denial of a requested service or item but approval of an alternative service or item;
 - v. the failure of the CHC-MCO to provide a service or item in a timely manner, as defined by the Department;
 - vi. the failure of a CHC-MCO to decide a Complaint or Grievance within the specified time frames;
 - vii. the denial of payment after a service or item has been delivered because the service or item was provided without authorization by a provider not enrolled in the MA Program;
 - viii. the denial of payment after a service or item has been delivered because the service or item is not a Covered Service for the Participant;
 - ix. the denial of a Participant's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other Participant financial liabilities.

- c. The request for a Fair Hearing must include a copy of the written notice of decision that is the subject of the request unless the CHC-MCO failed to provide written notice of the Complaint or Grievance decision within the time frames specified in this Exhibit. Requests must be sent to:
 - Department of Human Services
 - OLTL – CHC Program Complaint, Grievance and Fair Hearings
 - P.O. Box 2675
 - Harrisburg, Pennsylvania 17105-2675
- d. A Participant who files a request for a Fair Hearing that disputes a decision to discontinue, reduce, or change a service or item that the Participant has been receiving must continue to receive the disputed service or item at the previously authorized level pending resolution of the Fair Hearing, if the request for a Fair Hearing is hand delivered or postmarked within ten (10) days from the mail date on the written notice of decision.
- e. Upon receipt of the request for a Fair Hearing, BHA or the Department's designee will schedule a hearing. The Participant and the CHC-MCO will receive notification of the hearing date by letter at least ten (10) days before the hearing date, or a shorter time if requested by the Participant. The letter will outline the type of hearing, the location of the hearing (if applicable), and the date and time of the hearing.
- f. The CHC-MCO is a party to the hearing and must be present. The CHC-MCO, which may be represented by an attorney, must be prepared to explain and defend the issue on appeal. BHA's decision is based solely on the evidence presented at the hearing. The absence of the CHC-MCO from the hearing will not be reason to postpone the hearing.
- g. The CHC-MCO must provide Participants, at no cost, with records, reports, and documents, relevant to the subject of the Fair Hearing.
- h. BHA will issue an adjudication within ninety (90) days of the date the Participant filed the first level Complaint or the Grievance with the CHC-MCO, not including the number of days before the Participant requested the Fair Hearing. If BHA fails to issue an adjudication within ninety (90) days of receipt of the request for the Fair Hearing, the CHC-MCO must comply with the requirements at 55 Pa. Code § 275.4 regarding the provision of interim assistance upon the request for such by the Participant. When the Participant is

- responsible for delaying the hearing process, the time limit by which final administrative action must be taken prior to interim assistance being afforded will be extended by the length of the delay attributed to the Participant.
- i. BHA's adjudication is binding on the CHC-MCO unless reversed by the Secretary of Human Services. Either party may request reconsideration from the Secretary within fifteen (15) days from the date of the adjudication. Only the Participant may appeal to Commonwealth Court within thirty (30) days from the date of the BHA adjudication or from the date of the Secretary's final order, if reconsideration was granted. The decisions of the Secretary and the Court are binding on the CHC-MCO.

2. Expedited Fair Hearing Process

- a. A Participant or the Participant's representative may file a request for an expedited Fair Hearing with the Department either in writing or orally.
- b. A Participant must exhaust the Complaint or Grievance process prior to filing a request for an expedited Fair Hearing.
- c. BHA will conduct an expedited Fair Hearing if a Participant or a Participant's representative provides the Department with a signed written certification from the Participant's Provider that the Participant's life, physical or mental health, or ability to attain, maintain, or regain maximum function would be placed in jeopardy by following the regular Fair Hearing process or if the Provider provides testimony at the Fair Hearing which explains why using the usual time frames would place the Participant's health in jeopardy.
- d. A Participant who files a request for an expedited Fair Hearing to dispute a decision to discontinue, reduce, or change a service or item that the Participant has been receiving must continue to receive the disputed service or item at the previously authorized level pending resolution of the Fair Hearing, if the request for an expedited Fair Hearing is made verbally, hand delivered, or postmarked within ten (10) days from the mail date on the written notice of decision.
- e. Upon the receipt of the request for an expedited Fair Hearing, BHA or the Department's designee will schedule a hearing.
- f. The CHC-MCO is a party to the hearing and must be present. The CHC-MCO, which may be represented by an attorney, must be

- prepared to explain and defend the issue on appeal. The absence of the CHC-MCO from the hearing will not be reason to postpone the hearing.
- g. The CHC-MCO must provide the Participant, at no cost, with records, reports, and documents relevant to the subject of the Fair Hearing.
 - h. BHA has three (3) business days from the receipt of the Participant's oral or written request for an expedited review to process final administrative action.
 - i. BHA's adjudication is binding on the CHC-MCO unless reversed by the Secretary of Human Services. Either party may request reconsideration from the Secretary within fifteen (15) days from the date of the adjudication. Only the Participant may appeal to Commonwealth Court within thirty (30) days from the date of adjudication or from the date of the Secretary's final order, if reconsideration was granted. The decisions of the Secretary and the Court are binding on the CHC-MCO.

E. Provision of and Payment for Service or Item Following Decision

1. If the CHC-MCO, BHA, or the Secretary reverses a decision to deny, limit, or delay a service or item that was not furnished during the Complaint, Grievance, or Fair Hearing process, the CHC-MCO must authorize or provide the disputed service or item as expeditiously as the Participant's health condition requires but no later than seventy-two (72) hours from the date it receives notice that the decision was reversed. If the CHC-MCO requests reconsideration, the CHC-MCO must authorize or provide the disputed service or item pending reconsideration unless the CHC-MCO requests a stay of the BHA decision and the stay is granted.
2. If the CHC-MCO, BHA, or the Secretary reverses a decision to deny authorization of a service or item, and the Participant received the disputed service or item during the Complaint, Grievance, or Fair Hearing process, the CHC-MCO must pay for the service or item that the Participant received.

Appendix D: Enrollment Notices

The Department of Human Services (DHS) has a webpage dedicated to CHC [consumer communications](#) including:

Notices

DHS mailed the following notices to participants:

- [Nursing Facility Participant Notice CM 583](#)
- [HCBS Non-Dual Participant Notice CM 579](#)
- [HCBS Dual Participant Notice CM 577](#)
- [Duals Notice CM 581](#)

Pre-Enrollment Packets

DHS mails pre-enrollment packets for those transitioning to CHC to participants containing information about the MCOs and benefits, and how to enroll in a health plan. These are sent in the months prior to the first start date of CHC in the zone.

- Enrollment Brochure - [English](#) | [Spanish](#)
- Plan Comparison Chart with Long-Term Services and Supports - [English](#) | [Spanish](#)
- Plan Comparison Chart with Adult Benefit Package Only - [English](#) | [Spanish](#)

Post-Enrollment Packets

DHS mails notices after enrollment has been processed. These are the templates of the notices.

- Post-Enrollment Confirmation Letter - [English](#)
- Enrollment Assignment Letter - [English](#)
- Non-Discrimination Agreement - [English](#)
- LIFE Program - [English](#)

Appendix E: Denial Notices

The CHC-MCOs are required to use standardized denial notices, when they deny a service. These notices have been drafted by the state and given to the CHC-MCOs as templates. The templates are expected to be posted soon on the [Community HealthChoices website](#).

Appendix F: Grievance and Appeals Notices

The CHC-MCOs are required to use standardized grievance and appeal notices. These notices have been drafted by the state and given to the CHC-MCOs as templates. The templates are expected to be posted soon on the [Community HealthChoices website](#).

Appendix G: Helpful Contacts

CARIE

Center for Advocacy for the Rights and Interests of the Elderly (CARIE) - can help consumers with advocacy, options counseling, problem resolution, and where to turn for the assistance they need. Assists professionals with free case consultation. At same contact, CARIE's T-SAP helps with transportation advocacy and mobility management and the PA-SMP project that helps address issues related to Medicare and Medicaid fraud.

- 215-545-5728 or 1-800-356-3606
- www.carie.org

DHS CHC Website

- DHS has a [CHC webpage](#) with information including communications sent to Participants, publications, as well as resources for both consumers and providers.
- [Click here to subscribe](#) to the latest CHC news sent by OLTL.
- DHS has a webpage about the [MLTSS \(CHC\) Advisory Committee](#).

Legal Services

Community Legal Services of Philadelphia (CLS)

- 215-981-3700
- www.clsphila.org

Local Legal Services – Pennsylvania Legal Aid Network

- Find your local program at www.palegalaid.net

Pennsylvania Health Law Project (PHLP)

- 1-800-274-3258
- www.phlp.org

Protective Services

Adult Protective Services (APS): The APS Law establishes a program of protective services in order to detect, prevent, reduce and eliminate abuse, neglect, exploitation and abandonment of adults in need. Protective services are available to adults between 18 and 59 years of age who have a physical or mental impairment that substantially limits one or more major life activities.

- The statewide protective services hotline, 1-800-490-8505, is available 24 hours a day. If someone is at imminent risk, call 911.

Older Adult Protective Services (OAPS): Protective services are available for any older adult, age 60 or older, who is being abused, neglected, exploited, or abandoned.

- Anyone who suspects abuse may call-in a report 24 hours/day with by calling the statewide abuse hotline at 1-800-490-8505. If someone is at imminent risk, call 911.

Quality Care and Access Complaints

Beneficiary Support System (BSS) – *information pending*

Long-Term Care Ombudsman Program (LTCOP) – advocates for consumers of long-term care services and investigates and works to resolve their complaints and problems.

- To contact an ombudsman, call your local [Area Agency on Aging](#) or call the number found on posters located within facilities.

Pennsylvania Department of Health (DOH) – licenses and regulates health care providers in Pennsylvania such as nursing homes, hospitals, and home care agencies. DOH also investigates [complaints](#).

- Quality Assurance Complaint Hotline at 1-800-254-5164

Livanta, the Beneficiary and Family Centered Care Quality

Improvement Organization (BFCC-QIO) - The [BFCC-QIO](#) can help with Medicare complaints for beneficiaries in Pennsylvania, including those enrolled in HMOs and Medicare Advantage Plans.

- 866-815-5440, TTY: 866-868-2289

Medicare – Participants can send complaints directly to Medicare by submitting a [Medicare Complaint Form](#) or by calling Medicare at 1-800-MEDICARE (1-800-633-4227) or TTY/TTD 1-877-486-2048.

Office of Civil Rights at the U.S. Department of Justice – handles complaints about language access and disability rights including accessibility.

- More information about [filing an ADA complaint](#) is available online.
- To file an ADA complaint, you may [file online](#) or send the [information requested](#) to:

US Department of Justice 950 Pennsylvania Avenue, NW

Civil Rights Division
Disability Rights Section 1425 NYAV
Washington, D.C. 20530
Fax: (202) 307-1197

- If you have questions about filing an ADA complaint, please call:
ADA Information Line: 800-514-0301 (voice) or 800-514-0383 (TTY).

Pennsylvania Office of Attorney General - [Civil Rights Enforcement Section](#)

- To file a Civil Rights Complaint online, click [here](#).
- To print a form to mail in, click [here](#).

Office of Attorney General
Civil Rights Enforcement Section
14th Floor, Strawberry Square
Harrisburg, PA 17120
(717) 787-0822

Pennsylvania Office of Attorney General – [Health Care Section](#)

- You can contact the Health Care Section at 1-717-705-6938 on weekdays from 8:30 AM until 5:00 PM. The Section also has an in-state toll-free line, 1-877-888-4877.
- Click [here](#) to file a Health Care Complaint online.
- [Health Care PDF Form](#)
- All documents related to health care complaints should be sent to the following address:

Office of Attorney General
Health Care Section
14th Floor, Strawberry Square
Harrisburg, PA 17120

The Bureau of Equal Opportunity - handles complaints about language access and disability rights as well as discrimination based on race, color, national origin, age, disability, sex, gender identity or expression, or sexual orientation. Complaints can be filed by mail, fax, or email.

Room 223, Health and Welfare Building P.O. Box 2675
Harrisburg, PA 17105-2675
Phone: (717) 787-1127
TTY: (800) 654-5484
Fax: (717) 772-4366
Email: RA-PWBEOAO@pa.gov

Appendix H: Other Resources

AAAs/Aging Well - Local [Area Agencies on Aging \(AAAs\)](#) help older adults and their caregivers identify and get connected to needed programs and services. (You may also contact CARIE for referral to a local AAA.)

Aging and Disability Resource Centers (ADRCs), also known as PA LINK - [ADRCs](#) can help with CHC enrollment applications, and identifying community resources and benefits.

- 1-800-753-8827

APPRISE, Pennsylvania's health insurance counseling and assistance program - [APPRISE](#) provides information, assistance, and referrals to help Medicare beneficiaries with any health insurance related issues including Medicare and Medicaid, and any public benefit program.

- 1-800-783-7067

Independent Enrollment Broker (IEB) –

- 1-844-824-3655 (TTY: 1-833-254-0690)
- www.enrollchc.com

Pennsylvania Senior Medicare Patrol (PA-SMP) – [PA-SMP](#) helps with issues related to fraud and marketing abuses.

- 1-800-356-3606

Public Partnerships, LLC (PPL) – [PPL](#) is the Financial Management Services (FMS) contractor for Pennsylvania.

- 1-877-908-1750

Appendix I: Glossary

ACCESS Card — An identification card issued by the Department of Human Services to each Medical Assistance/Medicaid Recipient.

Act 150 – A state funded attendant care program providing personal assistance and other HCBS to people with physical disabilities from age 18 through 59. Consumers may pay a co-payment for services based on a sliding fee scale.

Activities of Daily Living (ADL) – Basic personal everyday activities that include bathing, dressing, transferring (e.g. from bed to chair), toileting, mobility and eating. The extent to which a person requires assistance to perform one or more ADLs is often a level of care criteria. (Also see Instrumental Activities of Daily Living (IADL) listed later in the Glossary.)

Adult Protective Services (APS) – A program of protective services administered by the Department of Human Services to detect, prevent, reduce and eliminate abuse, neglect, exploitation and abandonment of adults between 18 and 59 years of age who have a physical or mental impairment that substantially limits one or more major life activity. (Also see Older Adult Protective Services (OAPS) listed later in the Glossary.)

Aging and Disability Resource Centers (ADRCs) – A single points of access, otherwise known as “no wrong door,” into the Long-Term Services and Supports (LTSS) system for older adults, people with disabilities, veterans, and caregivers. ADRCs provide information and assistance to individuals with all levels of income in obtaining LTSS. Almost three-quarters of Area Agencies on Aging (AAAs) provide ADRC tasks in their local communities.

Aging Waiver – A Medicaid funded program providing in-home services and supports to consumers who are age 60 and over. Participants must meet functional and financial eligibility requirements.

Area Agencies on Aging (AAAs) – Area Agencies on Aging (AAAs) are public or private non-profit agencies designated by the state to address the needs of all older adults in their area, including coordinating services to help older adults remain in their homes. Pennsylvania has 52 AAAs serving all 67 counties.

Attendant Care Waiver – Similar to the Act 150 program but participants must meet financial and clinical eligibility requirements for this Medicaid funded program serving people with physical disabilities from age 18 through 59. There are no required co-payments.

Balance Billing – Billing of a Participant by a provider when the CHC-MCO pays the provider less than the provider charged for a covered service, item, or drug. Balance billing is prohibited, and Participants should never be balance billed.

Behavioral Health Managed Care Organization (BH-MCO)— An entity, operated by county government or licensed by the Commonwealth as a risk-bearing HMO or PPO, which manages the purchase and provision of Behavioral Health Services under an agreement with the Department.

Behavioral Health Services — Mental health and substance use disorder services.

Capitation Payment – A fee the Department pays per month to a CHC-MCO for each Participant enrolled in its managed care plan to provide coverage of all Covered Services, whether or not the Participant receives the services during the period covered by the fee.

Centers for Medicare & Medicaid Services (CMS) — The federal agency within the U.S. Department of Health and Human Services responsible for oversight of the Medicare and Medicaid Programs.

Certified Review Entity (CRE) – An independent organization certified by the state to perform utilization review on behalf of managed care plans and/or to conduct external grievance appeal reviews.

Complaint — A dispute or objection regarding a participating Health Care Provider or the coverage, operations, or management of a CHC-MCO, which has not been resolved by the CHC-MCO and has been filed with the CHC-MCO or with DOH or PID, including but not limited to:

- a denial because the requested service or item is not a Covered Service;
- the failure of the CHC-MCO to provide a service or item in a timely manner, as defined by the Department;
- the failure of the CHC-MCO to decide a Complaint or Grievance within the specified time frames;

- a denial of payment by the CHC-MCO after a service or item has been delivered because the service or item was provided without authorization by a provider not enrolled in the MA Program;
- a denial of payment by the CHC-MCO after a 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.

A complaint is not a grievance, see “Grievance” below.

Covered Services - Services which CHC-MCOs are required to offer to Participants under CHC as specified in the [CHC-MCOs Agreement with the state](#), a draft copy of is available online.

Cultural Competency — The ability of individuals, as reflected in personal and organizational responsiveness, to understand the social, linguistic, moral, intellectual and behavioral characteristics of a community or population, and translate this understanding systematically to enhance the effectiveness of healthcare delivery to diverse populations.

Department – The Pennsylvania Department of Human Services (DHS).

Disenrollment — The process by which a Participant’s ability to receive services from a CHC-MCO is terminated.

Dual Eligible — An individual who is enrolled in both Medicare and Medicaid.

Dual Eligible Special Needs Plans (D-SNPs) – A Medicare Advantage Plan that primarily or exclusively enrolls individuals who are entitled to both Medicare and Medicaid from a State Plan under Title XIX (Medicaid).

Enrollment — The process by which a Participant is enrolled in a CHC-MCO.

Fee-for-Service (FFS) — Payment to Providers on a per-service basis for healthcare services provided to Recipients.

Formulary — A Department-approved list of outpatient drugs determined by the CHC-MCO’s Pharmacy and Therapeutics (P&T) Committee to have a

significant, clinically meaningful therapeutic advantage in terms of safety, effectiveness, and cost for the CHC-MCO Participants.

Functional Eligibility Determination (FED) – A determination of an individual’s clinical eligibility for LTSS.

Grievance — A request to have a CHC-MCO or utilization review entity reconsider a decision concerning the Medical Necessity and appropriateness of a Covered Service. A Grievance may be filed regarding a CHC-MCO’s decision to:

- deny, in whole or in part, payment for a service or item;
- deny or issue a limited authorization of a requested service or item, including a determination based on the type or level of service or item;
- reduce, suspend, or terminate a previously authorized service or item;
- deny the requested service or item but approve an alternative service or item; and
- deny a request for a Benefit Limit Exception (BLE).

A Grievance is not a complaint – see “Complaint” above.

Home and Community-Based Services (HCBS) — A range of services and supports provided to Participants in their homes and communities. These services include assistance with ADLs and IADLs, which promote the ability for older adults and adults with disabilities to live independently to the greatest degree and remain in their homes as long as possible.

Hospice - A coordinated program of home and/or inpatient care that provides non-curative medical and support services for persons certified by a physician to be terminally ill with a life expectancy of six (6) months or less. Hospice programs provide Participants and families with palliative and supportive care to meet the special needs arising out of physical, psychological, spiritual, social and economic stresses which are experienced during the final stages of illness and during dying and bereavement. Hospice services provided to Participants by Medicare approved hospice Providers are directly reimbursed by Medicare. Medicaid also covers hospice services.

Independent Enrollment Broker (IEB) — An independent and conflict-free entity contracted with the Department, which is responsible for providing choice counseling and enrollment services to Participants.

Individualized Back-Up Plan – An individualized plan that is developed as part of the Person-Centered Service Plan development process, which identifies the strategies to be taken in the event that routine services are not able to be delivered to a Participant which, depending on the Participant's preferences and choice, may include, but are not limited to the use of family and friends of the Participant's choice, and/or agency staff. Back-up plans should also include disaster planning.

Instrumental Activities of Daily Living (IADL) - Activities related to independent living, including preparing meals, managing money, shopping for groceries or personal items, performing light or heavy housework, and communication. The extent to which a person requires assistance in performing IADLs is often assessed in conjunction with the evaluation of level of care. (Also see Activities of Daily Living (ADL) listed earlier in the Glossary.)

Living Independence for the Elderly (LIFE) - A comprehensive service delivery and financing program model in Pennsylvania (which is known nationally as the Program of All-Inclusive Care for the Elderly (PACE)) that provides comprehensive healthcare services under dual capitation agreements with Medicare and the Medical Assistance Program as an alternative to CHC for individuals age 55 and over who are Nursing Facility Clinically Eligible (NFCE) and reside in a LIFE service area.

Long-Term Care Ombudsman – A person or entity appointed to investigate and resolve issues or problems with and on behalf of a consumer. Pennsylvania's Long-Term Care Ombudsman Program provides advocacy services to consumers of LTSS in the following settings: nursing homes, licensed personal care and assisted living residences, adult day services centers and domiciliary care homes. Licensed settings that are part of a Continuing Care Retirement Community are also included.

Long-Term Services and Supports (LTSS) – A broad range of services and supports designed to assist an individual with ADLs and IADLs which can be provided in a home and community-based setting, a nursing facility, or other residential setting. LTSS may include but are not limited to: self-directed care; adult day health; personal emergency response systems; home modification and environmental accessibility options; home and personal care; home health; nursing services; specialized medical equipment and supplies; chore services;

social work and counseling; nutritional consultation; home-delivered meals and alternative meal service; and nursing facility services.

Managed Care Organization (MCO) — An entity that manages the purchase and provision of Physical Services and/or LTSS, under the CHC Program. The three MCOs operating CHC-MCOs are AmeriHealth Caritas/Keystone First, Pennsylvania Health and Wellness, and UPMC.

Marketing – Any communication from the CHC-MCO, or any of its agents or independent contractors, with a Participant or Potential Participant, who is not enrolled in the CHC-MCO that can reasonably be interpreted as intended to influence that individual to enroll in the CHC-MCO or remain enrolled in that particular CHC-MCO, or to disenroll from or not enroll in another CHC-MCO.

Medicaid or Medical Assistance (MA) — The Medical Assistance Program authorized by Title XIX of the federal Social Security Act, 42 U.S.C. 1396 et seq., and regulations promulgated thereunder, and 62 P.S. §441.1 et seq. and regulations at 55 PA Code Chapters 1101 et seq. Medicaid is a jointly funded federal and state program that covers health care and other related benefits such as Medicare out-of-pocket costs, nursing home care, and home and community-based services for certain people with low incomes and limited assets.

Medical Assistance Transportation Program (MATP) — A non-emergency medical transportation service provided to eligible persons who need to make trips to or from any Medical Assistance service for the purpose of receiving treatment, medical evaluation, or purchasing prescription drugs or medical equipment.

Medically Necessary (also referred to as Medical Necessity)— A Covered Service is Medically Necessary if it is compensable under the Medical Assistance Program and if it meets any one of the following standards:

- The Covered Service will, or is reasonably expected to, prevent the onset of an illness, condition or disability.
- The Covered Service will, or is reasonably expected to, reduce or ameliorate the physical, mental or developmental effects of an illness, condition, injury or disability.
- The Covered Service will assist the Participant to achieve or maintain maximum functional capacity in performing daily activities, taking into

account both the functional capacity of the Participant and those functional capacities that are appropriate for Participants of the same age.

Medicare — A federally-financed health insurance program administered by the Centers for Medicare and Medicaid Services (CMS) pursuant to 42 U.S.C. 1395 et seq., covering nearly all Americans sixty-five (65) years of age and older and certain individuals under sixty-five (65) who are disabled or have chronic kidney disease.

Network — All contracted or employed Providers in the CHC-MCO who are providing Covered Services to Participants.

Network Provider — A Medical Assistance enrolled healthcare provider who has a written provider agreement with and is credentialed by a CHC-MCO and who participates in the CHC-MCO's provider network to serve CHC Participants.

Non-Medical Transportation — Non-medical transportation includes transportation to community activities, grocery shopping, religious services, Adult Day Services centers, employment and volunteering, and other activities or LTSS services as specified in the Participant's PCSP.

Non-participating Provider — A Provider, whether a person, firm, corporation or other entity, either not enrolled in the Pennsylvania Medical Assistance Program or not participating in the CHC-MCO's Network.

Nursing Facility (NF) or Nursing Home — A general, county or hospital-based nursing facility, including those that are a part of a Continuing Care Retirement Community, licensed by the DOH.

Nursing Facility Clinically Eligible (NFCE) — Having clinical needs that require the level of care provided in a Nursing Facility.

Office of Long-Term Living (OLTL) — The program office within DHS responsible for the implementation and oversight of CHC.

Older Adult Protective Services (OAPS) — A program of protective services administered by the Department of Aging to protect Pennsylvanians 60 years of age and older against physical, emotional, or financial abuse as well as

exploitation, neglect, or abandonment. Reporting of abuse is mandatory for staff in certain licensed care settings but is voluntary for all others. (Also see Adult Protective Services (APS) listed earlier in the Glossary.)

Out-of-Network Provider — A Provider who has not been credentialed by and does not have a signed Provider Agreement with a CHC-MCO.

OPTIONS – A program funded by the Lottery and offered by the Pennsylvania Department of Aging to provide HCBS to eligible Pennsylvanians who are age 60 or older. Consumers may pay co-payments based on a sliding fee scale.

Participant — An eligible individual who is enrolled with a CHC-MCO under the CHC Program.

Participant Advisory Committee (PAC) – A group convened in person, at least quarterly, by the CHC-MCO to solicit input for consideration by the CHC-MCO's governing board which is open to all Participants and which reflects the diversity of the CHC-MCO's Participant population.

Participant-Direction – The opportunity for a Participant to exercise choice and control in identifying, accessing, and managing LTSS Covered Services and other supports in accordance with their needs and personal preferences.

Person-Centered Planning Team (PCPT) — The team of individuals that will participate in Person-Centered Service Planning with and provide person-centered coordinated services to Participants. Each Participant who has LTSS needs must have a PCPT.

Person-Centered Service Plan (PCSP) - A written description of Participant-specific healthcare, LTSS, and wellness goals to be achieved, and the amount, duration, frequency and scope of the Covered Services to be provided to a Participant in order to achieve such goals and based on the comprehensive needs assessment of the Participant's healthcare, LTSS and wellness needs. The Person-Centered Service Plan is developed by the Service Coordinator and the Participant and their supports. The Person-Centered Service Plan will consider the current and unique psycho-social and medical needs and history of the Participant, as well as the Participant's functional level and support systems and clinical and non-clinical needs. The Person-Centered Service Plan addresses how non-Covered Services necessary to support the healthcare and other goals of the Person-

Centered Service Plan will be accessed or coordinated. For Participants receiving LTSS, the PCPT is included in the development of the plan.

Person-Centered Service Planning (Service Planning) – The process of developing an individualized Person-Centered Service Plan based on an assessment of needs and preferences of the Participant. Service Planning considers both in and Out-of-Network Covered Services to support the individual in the environment of their choice and includes caregivers support needs.

Potential Participant — An individual who either is an Eligible Individual or is not yet an Eligible Individual but may become an Eligible Individual in the foreseeable future.

Primary Care - All healthcare services and laboratory services customarily furnished by or through a general practitioner, family physician, internal medicine physician, or obstetrician/gynecologist acting within the scope of their licensure.

Primary Care Practitioner (PCP) — A specific physician, physician group, clinic, or a Certified Registered Nurse Practitioner (CRNP) operating under the scope of their licensure, who is responsible for supervising, prescribing, and providing primary care services; locating, coordinating and monitoring other medical care and rehabilitative services, and maintaining continuity of care on behalf of a Participant.

Prior Authorization — A determination made by the CHC-MCO to approve or deny payment for a Provider's request to provide a Covered Service or course of treatment of a specific duration and scope to a Participant prior to the Provider's initiation or continuation of the requested service.

Provider — A licensed hospital or healthcare facility, medical equipment supplier, person, firm, corporation, or other entity who is licensed, certified or otherwise authorized to provide healthcare services under the laws of the Commonwealth or other state(s). The term includes but is not be limited to the following: physician, podiatrist, optometrist, psychologist, physical therapist, certified registered nurse practitioner, registered nurse, clinical nurse specialist, certified registered nurse anesthetist, certified nurse midwife, physician's assistant, chiropractor, dentist, dental hygienist, pharmacist, home care agency,

durable medical equipment supplier, LTSS provider, or behavioral health service provider.

Restraint — A restraint can be physical or chemical.

- A physical restraint includes any apparatus, appliance, device or garment applied to or adjacent to a resident's body, which restricts or diminishes the resident's level of independence or freedom.
- A chemical restraint includes psychopharmacologic drugs that are used for discipline or convenience and not required to treat medical symptoms.
- A device used to provide support for functional body position or proper balance and a device used for medical treatment, such as sand bags to limit movement after medical treatment, a wheelchair belt that is used for body positioning and support or a helmet for prevention of injury during seizure activity, are not considered mechanical restraints.

Seclusion – The involuntary confinement of an individual alone in a room or an area from which the individual is physically prevented from having contact with others or leaving.

Service Area – The geographic zone or zones in which the CHC-MCO has been approved to operate.

Service Coordination – Activities to identify, coordinate and assist Participants to gain access to needed Covered Services and non-Covered Services such as social, housing, educational and other services and supports. Service Coordination includes the primary functions of providing information to Participants and facilitating access, locating, coordinating and monitoring needed services and supports for Participants.

Service Coordinator - An appropriately qualified professional who is the CHC-MCO's designated accountable point of contact for each Participant's Person-Centered Service Planning and Service Coordination.

Services My Way (SMW) – The Budget Authority model of participant-directed service, sometimes called "cash and counseling", which provides Participants the opportunity to hire and manage staff that performs personal assistance type services, manage a flexible spending plan, and purchase allowable goods and services through their spending plan.

State – State means the Commonwealth of Pennsylvania in this handbook.

Vital documents — Documents which contain information that is critical for obtaining benefits. This includes documents such as provider directories, Participant handbooks, appeal and grievance notices and other notices that are critical to obtaining services, and, therefore, would have to be made available in each prevalent non-English language in its service area.

Waiver – One of many options available to states to allow the provision of long-term services and supports in home and community-based settings under the Medicaid Program.

Appendix J: Acronyms

ADRC	Aging and Disability Resource Centers (also known as PA Link).
APS	Adult Protective Services.
BH	Behavioral Health.
BH-MCO	Behavioral Health Managed Care Organization.
CARIE	The Center for Advocacy for the Rights and Interests of the Elderly.
CHC	Community HealthChoices.
CHC-MCO	Community HealthChoices Managed Care Organization.
CLS	Community Legal Services.
CMS	Centers for Medicare and Medicaid Services.
CRE	Certified Review Entity.
DME	Durable Medical Equipment.
DOH	Department of Health (of the Commonwealth of PA).
DHS	Department of Human Services (of the Commonwealth of PA).
D-SNP	Dual Eligible Special Needs Plan.
FED	Functional Eligibility Determination.
FFS	Fee For Service.
HCBS	Home and Community-Based Services.
IEB	Independent Enrollment Broker.
LTSS	Long-Term Services and Supports.
LIFE	Living Independence for the Elderly.
MA	Medical Assistance or Medicaid.
MATP	Medical Assistance Transportation Program.
MCO	Managed Care Organization.
NF	Nursing Facility.
NFCE	Nursing Facility Clinically Eligible.
OAPS	Older Adult Protective Services.
OBRA	Omnibus Budget Reconciliation Act.
OLTL	Office of Long-Term Living.
PCP	Primary Care Practitioner, includes a doctor or clinic.
PCSP	Person-Centered Service Plan.
PCPT	Person-Centered Planning Team.
PHLP	Pennsylvania Health Law Project.
PID	Pennsylvania Insurance Department.
QIO	the Quality Improvement Organization program led by CMS.
SNP	Special Needs Plan.