pennsylvania
DEPARTMENT OF HUMAN SERVICES

DATE: **December 7, 2017**

OPERATIONS MEMORANDUM #17-12-02

SUBJECT: Implementation of the Community HealthChoices (CHC) Program

TO: Executive Directors

FROM: Inez Titus
Director
Bureau of Operations

PURPOSE

To provide policy and procedures to County Assistance Offices (CAOs) regarding the implementation of the CHC program.

BACKGROUND

Under Governor Tom Wolf's leadership, the Pennsylvania Departments of Human Services (DHS) and Aging (PDA) have developed a new mandatory managed care program for older Pennsylvanians and adults with physical disabilities called CHC. The program will roll out in three phases over three years, beginning January 1, 2018. The first phase will be the Southwest region, which includes Allegheny, Armstrong, Beaver, Bedford, Blair, Butler, Cambria, Fayette, Greene, Indiana, Lawrence, Somerset, Washington and Westmoreland counties. The second phase will be the Southeast region, which includes Bucks, Chester, Delaware, Montgomery, and Philadelphia counties. The third phase will be the Northwest region, Lehigh-Capital and Northeast regions, which include all other counties not in phase one or two. CHC will serve an estimated 420,000 individuals, including over 100,000 older persons and adults with physical disabilities who are currently receiving Long Term Services and Supports (LTSS) in the community or are in nursing facilities.

The Commonwealth will coordinate physical and behavioral health and LTSS through CHC managed care organizations (CHC MCOs). Participants will have a choice of three CHC MCOs in each region. CHC will serve older persons and adults with physical disabilities who are currently receiving LTSS in the community or in nursing facilities. CHC will also serve the population that does not receive LTSS, but is dually eligible for Medicaid and Medicare (dual eligible participants). CHC MCOs will be accountable for most Medicaid-covered services, including preventative services, primary and acute care, LTSS (Home and Community Services (HCBS) and nursing facilities), prescription drugs, and dental services. Participants who have Medicaid and

Medicare coverage will have the option to have their Medicaid and Medicare services coordinated by the same MCO.

In addition to the CHC managed care changes for medical services, a new CHC waiver will be implemented by consolidating four current HCBS waivers. The waiver programs that will be consolidated into the CHC waiver are: Aging, Attendant Care, COMMCARE, and Independence. These waiver programs are currently managed by the DHS Office of Long-Term Living (OLTL), and will continue to do so. They are referred to as the OLTL Waivers. The Independence waiver has been amended to include services previously available in the COMMCARE waiver. Effective October 1, 2017, the COMMCARE waiver is no longer available.

DISCUSSION

The CHC population will include:

- Nursing Facility Ineligible Dual (NFI Dual) population
  - Adults age 21 or older who receive Medicaid and either Medicare A, B, C or D.
- Nursing Facility Clinically Eligible Dual (NFCE Dual) population
  - Adults age 21 or older who receive Medicaid and either Medicare A, B, C or D.
  - These individuals receive LTSS in either a private or a county nursing facility or in a community setting.
- Nursing Facility Eligible Non-Dual population
  - Adults age 21 or older, who receive Medicaid and who are not eligible for either Medicare A, B, C or D.
  - These individuals receive LTSS in either a private or a county nursing facility or in a community setting.

The CHC population will not include:

- Individuals under age 21
- Individuals receiving their services through the lottery funded Options program (Act 150) **Exception**: NFI Duals enrolled in Act 150 will be enrolled in CHC for their physical health services and will begin to receive their waiver services through Act 150.
- Individuals with intellectual/developmental disabilities (ID/DD), whether or not they receive services through the DHS Office of Developmental Programs (ODP)
- Residents of state-operated nursing facilities, including the State Veterans' Homes and South Mountain Restoration Center

Individuals who are included in the CHC population will be required to enroll in one of the CHC MCOs operating in that region unless they choose to enroll in the Living Independence for the Elderly (LIFE) program. The LIFE option is only available to the LTSS population that is 55 years of age or older. All individuals who choose LIFE rather

than CHC still must meet all the criteria for the LIFE program. The Independent Enrollment Broker (IEB), currently Maximus, will refer individuals to their local LIFE program. The IEB will assist individuals to voluntarily select one of the available CHC MCOs in their region. If an eligible individual does not select a CHC MCO or the LIFE program, he or she will be automatically assigned to one of the CHC MCO plans in the region. CHC participants may elect to switch from their current CHC MCO to a different CHC MCO in the region at any time by contacting the IEB. CHC MCO dating rules will follow HealthChoices (HC) dating rules. For plan transfers and NFI Dual enrollment, HC dating rules will apply. For newly enrolled LTSS participants, individuals will be enrolled the day after system processing.

The CHC benefit package will include all physical health benefits specified in the Medicaid State Plan. For dual eligible individuals, Medicare will continue to be the first payer for benefits covered under both programs. For CHC participants who are not eligible for Medicare Part D pharmacy benefits, CHC will provide Medicaid pharmacy benefit coverage through a formulary consistent with the State Plan. The CHC benefit package will include nursing facility services and HCBS currently covered in the OLTL waivers.

CHC will include provisions to help maintain continuity of care and avoid interruptions of service for participants when they are first enrolled in CHC, and when they choose to switch from one CHC MCO to another. Waiver participants enrolling in CHC as part of the transition into managed care will continue to have access to all waiver services and providers authorized in their service plan that were in effect the day before CHC enrollment. This continuity of care authorization will last for 180 days or until a new service plan is developed. If a participant chooses to transfer from one CHC MCO to another CHC MCO, the participant will continue to have access to all existing LTSS providers and must continue to receive any LTSS services in his or her service plan for 60 days from the date of the transfer or until a new service plan is developed. The continuity of care period for all other providers and after the initial 180 days is 60 days.

PROCEDURES

Financial Eligibility Determination

The Office of Income Maintenance (OIM) will continue to administer the Medicaid financial eligibility determination process through the CAOs. There are no changes to the current financial eligibility determination process and policy for the CAOs. All CAOs are to follow current policies and procedures for financial determinations for applications, renewals and inter-county transfers.

Level of Care Assessments

Individuals who are clinically eligible for LTSS when CHC starts will not need to go through a new level of care assessment prior to enrollment in CHC. Individuals who

are seeking LTSS services for the first time will have a level of care assessment as part of the overall eligibility determination process.

COMMCARE Waiver Ending

The COMMCARE waiver has been repurposed to the CHC waiver and will not be available statewide effective October 1, 2017. All COMMCARE recipients statewide, outside of CHC zone one, will be operationally transitioned to the Independence waiver by December 31, 2017. Individuals in CHC implementation zone one will be systematically transitioned to the CHC waiver with a begin date of January 1, 2018. Individuals who transition from COMMCARE to the Independence waiver will remain in their existing physical health HealthChoices (HC)/Fee For Service (FFS) plan and their existing behavioral health (BH) MCO. These individuals will not require a new financial determination, unless they have a renewal scheduled for the transition period.

If a CAO receives a HCBS Eligibility/Ineligibility/Change Form (PA1768) for an individual requesting the COMMCARE waiver after October 1, 2017, or with a service begin date on or after October 1, 2017, the CAO must contact the IEB for clarification, as this waiver cannot be selected. The CAO is not to assume that the individual should be placed in the Independence waiver in lieu of COMMCARE.

OBRA Waiver

Individuals who are currently enrolled in the OBRA wavier (code 79), are age 21 or over, residing in a CHC zone and:

- assessed as Nursing Facility Clinically Eligible (NFCE) will be enrolled systematically into the CHC waiver as of transition via a file which will identify them as NFCE.
- assessed as Nursing Facility Ineligible (NFI) will remain in the Omnibus Reconciliation Act (OBRA) waiver. Nothing needs to be done systematically or operationally by the CAO to this population.

As of January 1, 2018, OBRA will serve individual who are:

- 18-21 years old and assessed to be NFCE.
- assessed NFI with an Intermediate Care for Persons with Other Related Conditions (ICF/ORC) level of care.

Operational/System Impacts

Waiver Start Date

Currently, the CAOs enter the waiver start date as either the ‘Service Begin Date’ or the ‘Assessment Date’ if there is no ‘Service Begin Date’ on the PA1768. With CHC implementation, the CHC waiver start date is the date waiver benefits are processed. The CAO must enter the actual date benefits are being processed on the Program

Request Screen and on the Waiver Screen in eCIS. This allows the individual to be enrolled in the CHC managed care plan the day after the benefits are processed. This procedure change only applies to the CHC waiver. Individuals cannot be enrolled into CHC retroactively. The CAO is to follow current policy for authorizing HCBS for all other waivers and LTC MA. If for any reason the CAO cannot fully commit the case and authorize benefits on the same day, they must return to the Program Request screen prior to submitting the case and assure that the begin date is changed to the processing date.

Example: Mr. A applies for the CHC waiver on January 9, 2018. The CAO has requested all documents for financial eligibility and has found Mr. A financially eligible for HCBS. On January 29, 2018, the CAO receives a PA1768 from the IEB that states Mr. A is functionally eligible for the CHC waiver. The CAO processes the application on February 2, 2018. In the 'CP' module, the CAO must set the date on the Program Request Screen as February 2, 2018 and run eligibility, finding Mr. A eligible for the CHC waiver effective February 2, 2018. Mr. A will be enrolled in the CHC managed care plan effective February 3, 2018.

The CAO must narrate these actions and scan the PA 1768 and manual notices as per current procedures.

HC to CHC HCBS

When an MA recipient enrolled in HC applies for the CHC waiver, the CAO is to process this request in one transaction/workflow systematically. The system generated PA162 will show the effective date as the process date in this instance, which is correct.

Notices and the IEB

The CAO must:

- enter the IEB on the Provider screen in eCIS for all individuals applying for or receiving LTSS,
- verify the IEB is listed on the Provider screen in eCIS for an individual who is a LIFE recipient and chooses to transfer to CHC (this will ensure that the IEB receives a notice of the change),
- assure that all applicable parties, including the IEB, receive a copy of any notice that is issued, and
- scan to the case record all manual notices sent.

Alerts

CHC is only available for individuals ages 21 and over. If an individual is under the age of 21 and a dual eligible, currently in a waiver, or in an LTC facility, they will be excluded from CHC enrollment. The individual will be served by either HC or FFS for physical health services. Upon reaching age 21, the system will create age alert 011

(Age 21–Review For Appropriate Category) to notify the worker to re-determine the individual's eligibility based on their age and circumstances. The worker must run eligibility to have the system evaluate the individual for CHC managed care enrollment. It is crucial that the worker take action on the age alerts timely to assure the individual is enrolled in the correct managed care plan as soon as they become eligible.

LIFE Participants Flyer

Participants in LIFE who do not have the opportunity to work with the IEB need to be notified that they have the option to move from LIFE to CHC, as an alternative program choice. After CHC implementation on January 1, 2018, active LIFE recipients will be mailed an informational flyer informing them that they have the option to choose services through the CHC waiver or LIFE, and contact information for the offices involved should the participant have questions or want to switch programs.

Paper Applications and IEB Referrals

For CHC, the IEB is responsible to coordinate activities for an applicant requesting LTSS, and to complete a functional eligibility determination. The IEB is also responsible to provide the applicant with plan counseling to complete an advanced plan selection that will be used for CHC enrollment if the applicant is determined eligible.

When the CAO receives a paper application for an OLTL waiver, the CAO will begin the financial eligibility determination and must inform the IEB that the application was received. The CAO must send a secure email to the IEB at paiebcao@maximus.com containing the following information about the HCBS applicant:

- First name
- Last name
- Full Social Security Number
- Date of birth
- Gender
- Mailing address (if separate from residential address)
- Residential address
- Telephone number(s)
- Authorized representative/Power of Attorney/Legal guardian name and contact telephone number(s)
- Individual or Master Client Identification (MCI) number assigned to the recipient
- Date application was received by CAO

NOTE: The IEB only needs the information listed. The CAO does not need to send the IEB a copy of the application.

When the IEB receives a paper application for an OLTL waiver, the IEB will enter the application into COMPASS, which will be routed to the CAO for a financial determination. If an applicant, community partner, or nursing facility submits an application via COMPASS, the application will be automatically routed to the CAO and to the IEB. This will inform the IEB to start working with the applicant regarding their functional eligibility and plan counseling.

Current and Former ODP Recipients

ODP serves individuals in Pennsylvania who have intellectual disabilities through waiver and county base-funded programs. ODP Waiver participants include those who are enrolled in the following waivers: Adult Autism, Consolidated, Person/Family Directed Support (P/FDS), Adult Community Autism Program (ACAP) and those in Intermediate Care for Individuals with Intellectual Disabilities (ICF/ID) and ICF/ORC facilities. An ODP waiver recipient who enters an LTC facility and is found eligible for LTC MA will be disenrolled from the ODP waiver and subsequently enrolled in CHC. If the individual is discharged from the facility and returns to ODP services in any capacity, they will be disenrolled from CHC, and be enrolled in HC.

Individuals in Personal Care Homes (PCH)

Individuals residing in PCH can also be eligible for CHC if they meet all other criteria, and are receiving residential rehabilitation services. Facility code 76 is used to designate an individual residing in a PCH. Entry of facility code 76 will block CHC enrollment; therefore, individuals eligible for the CHC waiver who reside in a PCH at the time of transition will be manually transitioned to CHC through the use of an OMAP exemption code. The exemption code 09 will be manually entered by OMAP, and will allow the individual to be enrolled in a CHC MCO plan in conjunction with the PCH facility code. When the CAO receives an application for PCH for a current MA recipient, they are to add the facility code 76 to the record, and run eligibility. The CAO will not wait for the program status code (PSC) to change to a 62 in eCIS before entering facility code 76. OMAP and OLTL will review daily reports and update the Managed Care screen as needed.

Monthly Spend-Down

Spend-down is still to be considered for individuals, whether they are applicants or recipients, when income exceeds applicable income limits. Existing spend-down criteria and procedures should be followed. Category/program status code PA/PJ/PM 21 or 22 and TA/TJ 22 will continue be used.

- For MA recipients without CHC waiver: Continue to follow spend-down procedures found in MA Handbook 368.4, 369.331 and 369.431.

- For CHC waiver applicants: Individuals with income exceeding 300% of the Federal Benefit Rate ($2,205 in 2017) should be reviewed for monthly NMP or ongoing MNO spend-down.

REMINDER: Waiver applicants can only be reviewed for NMP spend-down on a monthly basis, unless applying for LIFE.

Below are the operational steps to be taken by all parties to authorize spend-down:

1. **(Caseworker)** Authorize individuals eligible for MA spend-down effective the day after income was spent down on medical expenses. Do not enter a waiver code.
    - Example: CAO finds the participant has spent down income as of June 10. They run eligibility on June 13. An NCE is set for MA eligibility from June 11 (the day after income was spent down on medical expenses) through June 30.
2. **(Caseworker)** Send the system generated notice authorizing MA in a spend-down category.
3. **(Caseworker Supervisor/Manager)** Submit a ServiceNow ticket requesting waiver code 20 be added to the Waiver screen in CIS and the individual be enrolled in a CHC MCO.
    - In this example, the caseworker submits the ServiceNow request on June 13, and on June 14 Headquarters enters the waiver code starting June 13.
4. **(OMAP)** Enroll the individual in the appropriate CHC MCO as of the day after the processing date (consistent with defined enrollment rules), and update the ServiceNow ticket with the plan information, which will trigger an email to the caseworker supervisor/manager.
    - In this example, on June 15, OMAP would enroll the participant in CHC effective June 14, the day after the CAO processed eligibility.
5. **(Caseworker Supervisor/Manager)** Review the ServiceNow ticket comments and alert the caseworker to send the waiver eligibility notice.
    - In this example, this occurs on June 16.
6. **(Caseworker)** Send the manual waiver eligibility notice using the waiver spend down templates found in the LTC folder on Docushare. The effective date must be the begin date entered on the waiver screen.
    - In this example, on June 16, the caseworker would create and send the manual notice indicating “The CHC waiver is effective from June 13 to June 30.”

HC Applicant Determined LTC Ineligible

When a recipient of MA applies for LTC MA, the CAO is to follow procedures in LTC Handbook 404.3, and request all necessary information to determine LTC MA eligibility. The MA category is to remain open until a determination is made regarding LTC eligibility. If the individual fails to provide specific verifications necessary to determine eligibility for LTC MA then the CAO will reject the LTC application reason code 042

(failure to provide information). If the requested information is also needed to evaluate continued MA eligibility, then the CAO must also close MA benefits for failure to provide.

NOTE: If an individual is institutionalized, the CAO is not to close MA for institutionalization (reason code 056), if the individual is ineligible for LTC MA but remains MA eligible.

The CAO is to follow the steps below:

1. Close the MA budget and suppress the system notice.
2. Process the LTC MA application and reject LTC MA specific information such as resources, etc.
3. Send the system 042 rejection notice to the applicant, community spouse (if applicable), representative or Power of Attorney, and the facility.
4. Re-open the original MA category the day after the budget closed to prevent any lapse in coverage, and suppress the system notice if there are no changes in MA.
5. Once the MA is re-opened, the CAO is to access the case through maintenance mode and add the appropriate facility code to the case.
6. If any information results in a change in continuing MA eligibility, the CAO is to take appropriate action and send the appropriate notice.

   Example: Mr. A is a recipient of MA in a Healthy Horizons category in the community. His health declined so he was admitted to a LTC facility on March 3. The CAO receives a PA600L requesting a LTC MA begin date of March 3 on April 6. The CAO sends a pending verification list to the representative for all required asset verification for the look back period. Mr. A remains open in an MA category while LTC MA eligibility is being determined. The information was not received by the due date, so the CAO disposes of the application for failure to provide the necessary asset information for LTC MA. Since the information Mr. A did not provide was only needed to determine LTC MA eligibility, the CAO will re-open MA benefits with no lapse in coverage. Once the MA is re-opened, the CAO will access the case through maintenance mode and enter the facility code.

If the individual submits the requested information at a later date, the CAO is to follow reconsideration guidelines in LTC Handbook 479.1.

NEXT STEPS

1. Review this Operations Memorandum with appropriate staff.
2. Contact your Area Manager if you have any questions.
3. This Operations Memorandum will become obsolete when this information is updated in the Long-Term Care Eligibility and Medical Assistance Eligibility Handbooks.