Keystone First
Community HealthChoices (CHC)
Provider Orientation

Keystone First
Community HealthChoices

Delivering the Next
Generation
of Health Care

What We Are Going to Cover Today

- Introduction to Keystone First CHC
- CHC Program Information
- Service Coordination
- Quality Management
- Provider Services
- Claims and Billing
- Additional Important Information and Resources

This training presentation can be found on our website:

www.keystonefirstchc.com → For Providers → Training.

Our Pledge

Keystone First CHC is committed to treating our Participants with respect. The Plan, its Network Providers, and other Providers of service, may not intentionally segregate or discriminate against Participants based on race, color, creed, sex, religion age, national origin, ancestry, marital status, gender identity, language, Medicaid status, income status, program participation, health status, disease or pre-existing condition, anticipated need for health care, or physical or mental disability.

Eligibility

Individuals 21 and older who:

- Receive Medicaid-only coverage and receive or need Long-Term Services and Supports (LTSS).
  - These Participants may reside in community-based settings or in private or county nursing facilities.

OR

- Receive both Medicare and Medicaid coverage (Dual Eligible).
  - These Participants can include those with and without LTSS needs.

Individuals are not eligible if they are:

- Receiving LTSS in the OBRA waiver and are NOT nursing facility clinically eligible (NFCE);
- An Act 150 program participant, who is not dually eligible for Medicare and Medicaid;
- A person with an intellectual or developmental disability who is receiving services or is eligible to receive services through the Department of Human Services' Office of Developmental Programs; OR
- A resident in a state-operated nursing facility, including the state veterans' homes.

Dual-Eligible Special Needs Plan (D-SNP)

- **Dual Eligible Special Needs Plan (D-SNP)** is a Medicare Advantage Plan that primarily or exclusively enrolls individuals who are enrolled in both Medicare and Medicaid.
- This may include Community Well Dual (CWD) Participants.
- Participants who are NFI or NFCE who have Medicare and Medicaid can choose a D-SNP.
- Participants may choose a D-SNP that is aligned or unaligned with the Plan or remain in Medicare fee-for-service.

D-SNP Goal

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- The goal of Keystone First CHC and its companion D-SNP (Keystone First VIP Care) is to provide a coordinated experience from the perspective of Full Dual Eligible Participants who enroll in both.
- Includes but is not limited to an integrated assessment and care coordination process that spans all Medicaid and Medicare services.
- Administrative integration is expected to evolve over the life of CHC.
- Keystone First CHC will cooperate fully with the Department of Human Services (DHS) and Centers for Medicare & Medicaid Services (CMS) in ongoing efforts to streamline administration of the two programs, which may include, but is not limited to, coordinated readiness reviews, monitoring, enrollment, Participant materials, and appeals processes.

Financial Responsibility

- Keystone First CHC (Plan) will pay Medicare deductibles and coinsurance amounts relating to any Medicare-covered service for Dual Eligible Participants not to exceed the contracted Plan rate. The Plan will not be responsible for copayments or cost-sharing for Medicare Part D prescriptions.
- If no contracted Plan rate exists or if the Provider of the service is an Out-of-Network Provider, the Plan must pay deductibles and coinsurance up to the applicable Medical Assistance (MA) fee schedule rate for the service.
- For Medicare services that are not covered by MA or CHC, the Plan must pay cost-sharing to the extent that the payment made under Medicare for the service and the payment made by the Plan do not exceed eighty percent (80%) of the Medicare-approved amount.
- The Plan, its subcontractors and Providers are prohibited from balance billing Participants for Medicare deductibles or coinsurance. The Plan must provide a Dual Eligible Participant access to Medicare products and services from the Medicare Provider of his or her choice. The Plan is responsible to pay any Medicare coinsurance and deductible amount, whether or not the Medicare Provider is included in the Plan's Provider Network and whether or not the Medicare Provider has complied with the Prior Authorization requirements of the Plan.

Behavioral Health and Substance Use Benefits

- **Please note:** Under the CHC Program, behavioral health services are coordinated through, and provided by, the Participant's Behavioral Health Managed Care Organization (BH-MCO).
  - These services are not part of the Keystone First CHC benefit package, but are available to all Keystone First CHC Participants through the BH-MCOs.

- Participants may self-refer for behavioral health, drug, alcohol, and substance abuse services.

- Primary Care Providers (PCPs) and health care providers can obtain assistance for referrals for Participants identified as needing behavioral health, drug, alcohol and substance abuse services by accessing: https://www.enrollnow.net/learn/behavioral-health-services.

Service Coordination

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Service Coordination

- Keystone First CHC **facilitates and coordinates** Participants' access to all necessary covered services including Medicaid, Medicare, Behavioral Health, and other services.
- Seamless and continuous coordination and data sharing **across a continuum of services** for the Participant with a focus on improving healthcare outcomes and independent living.
- These activities are part of **Person-Centered Service Planning** (PCSP) and PCSP implementation process for Participants who have a PCSP.
- This is accomplished through **Service Coordinators**.

Service Planning and Coordination

The Service Coordinators' role is personal and includes face-to-face contact, to help Participants navigate the system and coordinate their care. They are a single point of contact for Participants with a primary function of providing information, facilitating access, locating, coordinating and monitoring needed services and supports for LTSS Participants.

Service Coordinators are responsible to inform Participants about:

- Available LTSS benefits.
- Required needs assessments.
- Participant-centered service planning process.*
- Service alternatives.
- Service delivery options including opportunities for Participant self- direction.
- Roles, rights including Department of Human Services (DHS) Fair Hearing rights, risks and responsibilities, and to assist with fair hearing requests when needed and requested.

Person-centered planning and self-direction are key foundations of LTSS.

Service Coordinators

- Protect a Participant's health, welfare and safety on an on-going basis.
- Collect additional necessary information, including, at a minimum, Participant preferences, strengths and goals to inform the development of the Person-Centered Service Plan (PCSP).
- Conduct reevaluation of level of care annually or more frequently as needed in accordance with DHS requirements.
- Assist the Participant and his or her Person-Centered Planning Team (PCPT) in identifying and choosing willing and qualified Providers.
- Coordinate efforts and prompt the Participant to complete activities necessary to maintain LTSS eligibility.
- Explore coverage of services to address Participant identified needs through other sources, including services provided under the State Plan, Medicare or private insurance and other community resources.
- Actively coordinate with other individuals and entities essential in the physical and behavioral care delivery for the Participant to provide for seamless coordination between physical, behavioral and support services.
- Are available during normal business hours and will return all provider calls within two business days.

Nursing Facility Clinically Eligible Assessment Process

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Based on the Community HealthChoices Agreement requirements for the NFCE, our Service Coordination Team will:

- Reach out to the Participant to schedule a face-to-face visit within 5 days of enrollment.
- Complete a comprehensive needs assessment at the initial face-to-face visit.
- Assist the Participant in identifying the PCPT.
- Assist the Participant in developing the PCSP.
- Authorize home and community-based services and custodial nursing facility stays.
- Assist the Participant and his or her PCPT in identifying and choosing willing and qualified Providers.

Comprehensive Needs Assessment

DHS has identified the ***InterRAI HC*** as the tool to be utilized for the Comprehensive Needs Assessment. InterRAI Home Care (HC) is the assessment tool for all CHC-MCOs.

Comprehensive Needs Assessment must be:

- Completed within 5 days of enrollment.
- Completed within 14 days of a change in condition (trigger event).
- Completed within 12 months of the last comprehensive assessment.

Service Coordinators will conduct an assessment, as described, using tools and processes previously noted for Participants who have been identified as potentially meeting the NFCE level of care.

Keystone First CHC will refer individuals who are identified as potentially eligible for LTSS to DHS or its designee for level of care determination, if applicable.

Person-Centered Service Plan (PCSP)

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The PCSP is the Participant's Plan of Care and includes:

- A written description of Participant-specific healthcare, LTSS, and wellness goals to be achieved.
- All services authorized including the amount, duration, frequency, and scope of the Covered Services to be provided to the Participant in order to achieve their goals.
- Acute and chronic conditions, current medications.
- A schedule of preventive service needs or requirements.
- Disease Management action steps.
- Known needed physical and behavioral healthcare and services.
- All designated points of contact and those authorized to request and receive information about the Participant's services.
- Participant's employment and education goals.
- Participant's emergency back-up plan.
- Self-direction and freedom of choice.
- Updated annually or with a change in condition (trigger event).

The PCSP is based on the comprehensive assessment of the Participant's healthcare, LTSS, and wellness needs and preferences.

Trigger Events

Trigger events are defined as:

- A significant healthcare event to include but not be limited to a hospital admission, a transition between healthcare settings, or a hospital discharge.
- A change in functional status.
- A change in caregiver or informal support status 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, caregiver, Provider, or the PCPT or PCPT member, or DHS.

Service Coordination and Care Transition

- Care transition protocols are implemented whenever Participants are admitted or discharged from hospitals, nursing facilities or residential settings.
- Service Coordinators work closely with the Discharge Planning Team (DPT) at hospitals, nursing facilities or residential settings to ensure a Participant's safe discharge.
- Our Nursing Home Transition (NHT) Team will coordinate all non-Money Follows the Person (MFP) discharges for Participants who are currently residing in a nursing facility but wish to live in a community setting.

Person-Centered Planning Team (PCPT)*

- A team of individuals ***identified by the Participant*** to participate in PCSP process.
- Team members understand the goals that are important to the Participant and support those goals.
- The PCPT will convene:
  - During the initial assessment as part of PCSP.
  - Before a potential change in condition.
  - After a trigger event.
  - Annually.
  - Upon request by the Participant or their representative.
- Providers are vital PCPT members with ***valuable input*** to ensure that the Participant successfully meets their goals.
- Service Coordinator's role is to facilitate the process, schedule the PCPT meetings, document the process, and update the PCSP as needed.

**** The PCPT approach must comply with the PCPT requirements of 42 C.F.R. § 441.301(c)(1) through (3) and of this Agreement.***

Provider Role in Service Planning

- Front line staff are our “eyes and ears” regarding Participant well-being. Notifying the Service Coordinator when there is a change in condition, hospital admission, change in caregiver status (trigger events) is crucial.

- Providers assist in identifying the subtle changes in the Participant’s physical health, mental health, and/or environment that could negatively impact the Participant’s care and quality of life.

- Communicating those subtle changes to the Service Coordinator will assist in getting the Participant the service and/or support needed and could prevent an admission to the hospital or nursing facility.

- The Plan strongly encourages providers to participate in the Person-Centered Planning Team (PCPT) meetings.

Communicating with Service Coordinators

- Providers should establish a relationship with the Service Coordinator, communicating by phone and email.
- Providers should inform the Service Coordinator about any trigger events, concerns about service level, cancelled shifts initiated by the Participant, or care concerns the provider is noticing.
- Providers should use the escalation mailbox: LTSSUM@amerihealthcaritas.com only when they are unsuccessful reaching the assigned Service Coordinator, or if there are "bulk" authorization correction needs.
- Providers need to communicate with the assigned Service Coordinator to establish who is going to take responsibility for entering the Critical Incident Report (as appropriate) via the Department's Enterprise Incident Management (EIM) System.**
- Missed shift information must be entered accurately and following HHAeXchange reporting requirements so that the Service Coordinator can act upon the information received.

*** Critical incident reporting will be reviewed in more detail by the Quality team. Remember, it is mandatory that the individual or entity that discovers or has first-hand knowledge of a Critical Incident, report it.*

Missed Shift Reporting

Please use correct reason codes for reporting missed shifts:

- AR: Participant refused services.
- HU: Unplanned hospitalizations only.
- UN: Agency unable to staff shift.
- IS: COVID-19 - Participant refused services, informal supports provided.
- SI: COVID-19 - Participant refused services, self-isolating.
- FA: Participant is in the hospital or nursing facility due to COVID-19.
- TX: Worker was switched to cover another case due to COVID-19.
- CV: Any other missed visit due to COVID-19 reasons not listed above.

Additional details are required, regardless of the reason code: provider comments should succinctly describe the circumstances of the missed shift.

If Health/Safety Risk = YES: the identified health or safety risk should be described in additional details.

No missed shifts should be reported if there is no active service authorization for these dates.

Prior Authorization

All LTSS services require prior authorization.

- The Service Coordinator is responsible for authorizing a Participant's LTSS services.
  - Refer to the LTSS section of the provider manual for a complete list of LTSS services.
- For prior authorization of LTSS services, contact the Participant's Service Coordinator. You can also direct message us through HHAeXchange.
- For prior authorization of medical services, contact our medical Utilization Management (UM) department at **1-800-521-6622.**

The provider manual can be found on our website: www.keystonefirstchc.com → For Providers → Provider manual and forms.

Participant Complaints, Grievances and Fair Hearings

- Please refer to the Keystone First CHC Provider Manual, Section VIII, for complete detailed information on **Participant Complaints, Grievances and Fair Hearing** rules, procedures and timeframes.
- **Important:** Providers acting as a Participant representative in the Participant Complaint, Grievance and Fair hearing processes must have proof of the Participant's written authorization for the representative to be involved and/or act on the Participant's behalf.

To view Participant Rights and Responsibilities information on our website, go to: www.keystonefirstchc.com → For Providers → Resources.

Quality of Services

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Quality of Care

- The World Health Organization (WHO) defines Quality of Care as “the extent to which health care services provided to individuals and patient populations improve desired health outcomes.” (World Health Organization 2018).
- This is accomplished through the safe delivery of patient centered care that is coordinated through Health Plans, Care and Service Care Providers, Participants, and Community Programs.
- Goal is to improve Participant outcomes through:
  - Continuity of Care.
  - Care Coordination.
  - Access to Care.
  - Decreased Disparity in Healthcare.
  - Disease Management.
  - Decrease in Medical Errors.
  - Improved Overall Health Outcomes.
  - Participant Satisfaction with Health Care Delivery.

Participant Quality of Care

- Our goal at Keystone First CHC is for Participants to receive the best Quality of Care from our network Providers.

- This is accomplished through measured Quality Activities that include:
  - Systematic Review of health service utilization performance.
  - Medical Record Audits.
  - Participant experience surveys (**CAHPS®:** Consumer Assessment of Healthcare Providers and Systems).
  - Measurements /Standards (**HEDIS®**: Healthcare Effectiveness Data and Information Set).
  - Clinical Case Reviews.

Quality of Care Review Process

- When a Quality of Care concern is identified, it triggers a series of events that are designed to help find the root cause of the incident. We work with the goal of safety for our Participants.

- Quality of Care cases are assigned to a Quality Specialist who will:
  - Document incident in data base.
  - Investigate circumstances surrounding incident.
  - Make recommendations for:
    - Provider re-education.
    - Process Improvement.
    - Corrective action plan for serious or repetitive incidents.
- Medical Director will determine the final decision for each case.

- Our goal is to help Providers make process improvements that are necessary to provide our Participants with the best possible Quality of Care.

Enterprise Incident Management (EIM)

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Enterprise Incident Management (EIM) is a comprehensive, web-based incident and complaint reporting system that will provide the capability to record and review incidents for Office of Long-Term Living (OLTL) program participants. EIM will also provide OLTL with the capability to record and review Participant complaints and link them to incidents as needed.

Providers will use EIM to:

- Record incidents.
- Investigate incidents.
- Track and trend incident data for quality improvement activities.

OLTL will continue to use Home and Community Services Information System (HCSIS), as they do today, for Participant, provider, plan and case management. EIM integrates with HCSIS to gather individual and provider information for use in incident reports.

Training materials for EIM may be found in HCSIS under the Learning Management System (LMS) tab at https://www.hcsis.state.pa.us.

Critical Incident Reporting

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Network Providers and Subcontractors must report critical incidents via the Department's EIM system, as well as inform the Participant's Service Coordinator.

- The first section needs to be entered into EIM and submitted within 48 hours from the discovery date.
- The final section needs to be completed and submitted prior to day 30 from the discovery date to allow time to complete the MCO-management review and submit on or before day 30 in accordance with timeframes set forth by OLTL.

Network Providers and Subcontractors working with CHC Participants EIM Access:

- Use the same User ID for all CHC Participants no matter what MCO they are enrolled with.
- Reach out to the HCSIS helpdesk at **1-866-444-1264** for EIM system access if don't already have it.
- Need the "Search for CHC Participants" checkbox in order to search for CHC Participants.
  - Contact the HCSIS helpdesk for assistance to add this checkbox if needed.
- Need to use the Participant's Medicaid ID (MCI) or Social Security Number (SSN) when entering the Identifier Type to search a Participant. This can be obtained from the Participant.
- If any questions contact the CI mailbox at: KFCHCCriticalincident@keystonefirstchc.com.

Critical Incident Reporting (continued)

Keystone First CHC must investigate critical events or incidents reported by Network Providers and Subcontractors and report the outcomes of these investigations.

Suspected Abuse, Neglect, and Exploitation should be verbally reported by calling the Protective Services Hotline at **1-800-490-8505.**

The following are critical incidents that must be reported:

- Death (other than by natural causes).
- Serious injury resulting in emergency room visits, hospitalizations, or death.
- Hospitalization (unplanned).
- Provider or staff misconduct, including deliberate, willful, unlawful, or dishonest activities.
- Abuse, which includes the infliction of injury, unreasonable confinement, intimidation, punishment, mental anguish, or sexual abuse of a Participant, including:
  - Physical abuse.
  - Psychological abuse.
  - Sexual abuse.
  - Verbal abuse.

Critical Incident Reporting

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- Neglect, which includes the failure to provide a Participant the reasonable care that he/she requires, including, but not limited to, food, clothing, shelter, medical care, personal hygiene, and protection from harm.

- Exploitation, which includes the act of depriving, defrauding, or otherwise obtaining the personal property from a Participant in an unjust, or cruel manner, against one's will, or without one's consent, or knowledge for the benefit of self or others.

- Restraint, which includes any physical, chemical or mechanical intervention that is used to control acute, episodic behavior that restricts the movement or function of the individual or a portion of the individual's body.

- Service interruption, which includes any event that results in the Participant's inability to receive services that places his or her health and or safety at risk. This includes involuntary termination by the provider agency, and failure of the participant's back-up plan.

- Medication errors resulting in hospitalization, an emergency room visit or other medical intervention.

Americans with Disabilities Act (ADA)

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THE LAW

The Americans with Disabilities Act of 1990 (ADA) prohibits discrimination and ensures equal opportunity for persons with disabilities in employment, State and local government services, public accommodations, commercial facilities, and transportation. It also mandates the establishment of TDD/telephone relay services. The ADA was revised by the ADA Amendments Act of 2008 (P.L. 110-325), which became effective on January 1, 2009. The ADA is codified at 42 U.S.C. 12101 et seq.

- Title III of the Americans with Disabilities Act (ADA) states that public accommodations must comply with basic non-discrimination requirements that prohibit exclusion, segregation, and unequal treatment of any person with a disability.
- Public accommodations (such as Health Care Providers) must specifically comply with, among other things, requirements related to effective communication with people with hearing, vision, or speech disabilities, and other physical access requirements.

ADA (continued)

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Providers are required to:

- Provide written and oral language assistance at no cost to Plan Participants with limited- English proficiency or other special communication needs, at all points of contact and during all hours of operation. Language access includes the provision of competent language interpreters, upon request.
- Provide Participants verbal or written notice (in their preferred language or format) about their right to receive free language assistance services.
- Post and offer easy-to-read Participant signage and materials in the languages of the common cultural groups in the Provider's service area. Vital documents, such as patient information forms and treatment consent forms, must be made available in other languages and formats.
- Discourage Participants from using family or friends as oral translators.
- Advise Participants that translation services are available through the Plan if the Provider is not able to procure necessary translations services for a Participant.

Cultural Competency

Department of Human Services (DHS) defines Cultural Competency as:

The ability of individuals 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.

Communication is the first step in establishing a physician-patient relationship.

If a Participant requires or requests translation services because they are either non-English or limited English speaking, have a preferred language, or the Participant has some other sensory impairment, the provider has a responsibility to make arrangement to procure translation services for those Participants, and to facilitate the provision of health care services.

Providers who are unable to arrange for translation services should contact Participant Services at **1-855-332-0729; TTY/TDD 1-855-235-4976** 24 hours a day, 7 days a week.

Cultural Competency (continued)

- Racial, ethnic, linguistic, gender, sexual orientation, gender identity and culture must not present barriers to Participants' access to and receipt of quality services.
- Providers should demonstrate willingness and the ability to make necessary accommodations in providing services, to employ appropriate language and language preference when referring to and speaking with people with disabilities, and to understand communication, transportation, scheduling, structural, and attitudinal barriers to accessing services.

Cultural Competency Resources and Training

- Keystone First CHC understands how important trust and a positive relationship between a patient and their health care provider can be to reducing barriers to care.
- With an aim to increase sensitivity, awareness, and knowledge, and to help decrease potential disparities, we offer opportunities to receive free Continuing Medical Education (CME) credits for ongoing cultural competency training on our website.
  - Please check often for updated resources and trainings at www.keysonefirstchc.com → For Providers → Training.

We offer resources and training specific to the health care needs of the LGBTQIA+ community.

  - Access this important information at www.keystonefirstchc.com → For Providers → Training.

Health Literacy

Health literacy is the ability to communicate with Participants in a way that is easy for them to understand and act upon.

- Participants with both high and low reading levels can have limited knowledge of health care resulting in low health literacy.
- Low health literacy is a growing problem and difficult to detect with no outward signs.
- Participants with low health literacy tend to be less compliant, which leads to lower quality of life and higher health care costs.
- Low health literacy leads to problems with understanding:
  - Physician instructions.
  - Consent forms.
  - Medical brochures.
  - Instructions for medications.

Health Literacy (continued)

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Strategies to improve health literacy:

- Build relationships.
- Take patient's values and preferences into account.

Ensure Understanding

- ✓ Use plain, everyday words or pictures that are clear.
- ✓ Provide easy-to-read health materials.
- ✓ Encourage dialogue about diagnosis or medications to determine comprehension.

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Whether you are face-to-face or on the phone with a non-English speaker, INTERPRETALK® Interpreting by Telephone (IBT) by LSA is the fastest and easiest way to communicate. Accessible by phone within seconds, our highly skilled and experienced telephonic interpreters are waiting to assist you in over 200 language offerings, 24 hours a day, 365 days a year. Supported by a state-of-the-art computer telephony integration system, our call center coordinators are trained to combine cutting-edge technology solutions with human interaction to provide you with unparalleled customer service support.

Face-to-Face Interpreting

Face-to-Face Interpreting

When you need an interpreter to be physically present.

When you need someone by your side when complete understanding is vital, LSA's Face-to-Face Interpreting service is your best solution. Our professional linguists are proficient in terminology and lexicon for virtually any subject area. Whether for conferences, client visits, events, examinations, medical treatments, investigations, or whatever your specific need may be, we will match you with an on-site interpreter that best suits your unique project needs.

Translation and Localization

Translation and Localization

For accurate, timely, culturally correct translations.

From the very simple to the extremely complex, you can always rely on LSA for true and meticulous written translations. We have an expansive network of native-speaking translators, possessing subject-specific expertise, to help you accomplish your unique project goals. One of the most important aspects of document translation is knowing who you are trying to reach. At LSA, we help you say what you really mean by localizing your content. Audience, usage, regionalisms, colloquialisms and terminology are all taken into consideration to ensure that the final product is faithful to your original intent.

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Video Remote Interpreting (VRI)

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LSA's Video Remote Interpreting (VRI) service is the industry's most advanced, comprehensive solution for clear, real-time, video communication with qualified and professional interpreters. Recommended applications for VRI include medical emergencies, clinical settings, physical therapy appointments, court proceedings, depositions, conferences, educational sessions, impromptu meetings, government services and wherever on demand interpretation is a necessity. LSA currently provides VRI services in Spanish and American Sign Language (ASL).

American Sign Language (ASL)

American Sign Language (ASL)

Signed. Spoken. Understood.

As an active organizational member of the national Registry of Interpreters for the Deaf (RID), LSA ensures all American Sign Language (ASL) interpreters abide by the Code of Professional Conduct, which includes an adherence to the standards of confidential communication. We are proud to provide RID certified and non-RID certified American Sign Language interpreters to meet your specific needs. Clients with specific certification requirements are encouraged to inquire about our roster of federal court, state court, and Consortium-certified linguists.

Intercultural Consulting

Intercultural Consulting

Achieving success in a global environment.

Achieving success in any global business hinges on truly understanding the values and customs of different cultures. Whether your business serves multicultural groups in the United States, or across the globe, our intercultural consultation service will help you gain the cultural proficiency necessary to succeed in a global marketplace. We are proud to have formed strategic partnerships with a wide range of Fortune 1000 companies, as well as a multitude of other organizations and institutions.

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Disputes and Appeals

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Medical Necessity Definition

The definition of Medical Necessity (also referred to as Medically Necessary) is that the service or item is compensable under the Medical Assistance (MA) Program and meets any one of the following standards:

- Will, or is reasonably expected to, prevent the onset of an illness, condition or disability.
- Will, or is reasonably expected to, reduce or ameliorate the physical, mental or developmental effects of an illness, condition, injury or disability.
- Will assist a 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.
- Will provide the opportunity for a Participant receiving long-term services and supports to have access to the benefits of community living, to achieve person-centered goals, and live and work in the setting of his or her choice.

Provider Disputes

A Provider **Dispute** is a written expression of dissatisfaction by a Network Provider regarding an Keystone First CHC (Plan) decision that directly impacts the Network Provider. Disputes are generally administrative in nature and **do not include decisions concerning medical necessity**.

Examples of Disputes include, but are not limited to:

- Service issues with the Plan.
- Issues with the Plan processes.
- Contracting issues.

Call Provider Services at **1-800-521-6007** for Disputes *not concerning medical necessity*; OR

Mail to: **Keystone First CHC**
Informal Provider Disputes
P.O. Box 7146
London, KY 40742 - 7146

- The Plan will investigate and conduct an on-site meeting with the Network Provider (if requested), and issue the informal resolution of the Dispute within sixty (60) calendar days of receipt of the Dispute from the Network Provider.
- Network Providers may appeal most Disputes not resolved to the Provider's satisfaction through the Informal Provider Dispute Process to the Plan's Formal Provider Appeals Process.
- Process for filing an appeal through the Plan's Formal Provider Appeals Process, including the mailing address for filing an appeal, are set forth in the "Formal Provider Appeals Process" Section of the Provider Manual at www.keystonefirstchc.com → For Providers → Provider manual and forms.

Claims Disputes

Claims disputes include claim denials, payments the Network Provider feels were made in error by the Plan, or involve a larger volume of claims that cannot easily be handled by phone.

Network Providers must submit claims disputes to the Plan within 365 days from the date of service, or the date compensable items were provided, with a written explanation of the error to:

Keystone First CHC
Claims Disputes
P.O. Box 7146
London, KY 40742-7146

For accurate and timely resolution of issues, Network Providers should include the following information:

- Provider name.
- Provider number.
- Tax ID number.
- Number of claims involved.
- Claim numbers, as well as a sample of the claim(s).
- A description of the denial issue.

Provider Appeals

An **Appeal** is a written request from a Health Care Provider for the reversal of a denial by the Plan, through its Formal Provider Appeals Process, with regard to two (2) major types of issues:

1. Disputes not resolved to the Network Provider's satisfaction through the Plan's Informal Provider Dispute Process

2. Denials for services already rendered by the Provider to a Participant including denials that:

   (a)Do not clearly state the Health Care Provider is filing a Participant Complaint or Grievance on behalf of a Participant (even if the materials submitted with the Appeal contain a Participant consent) **or**

   (b)Do not contain a Participant consent for a Participant Complaint or a consent that conforms with applicable law for a Grievance filed by a Health Care Provider on behalf of a Participant (see Provider Initiated Participant Appeals in Keystone First CHC Provider Manual for required elements of a Participant consent for a Grievance.)

Provider Appeals

Written request for the reversal of a medical denial:

Inpatient Appeals
Keystone First CHC
P.O. Box 80111
London, KY 40742-0111

Outpatient Appeals
Keystone First CHC
P.O. Box 80113
London, KY 40742-0113

Provider Services

Keystone First

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Addressing Provider Issues

- Provider Issues will be addressed initially by the Provider Service's phone unit.
- All issues not resolved at this level will be referred to your designated Provider Account Executive.
- Provider Services can be reached at **1-800-521-6007.**

Provider Services

Our Provider Services Department operates in conjunction with the Provider Network Management Department, answering Network Provider concerns, and offering assistance, to help ensure all Network Providers receive the highest level of service available.

- Phone **1-800-521-6007,** 24 hours/7 days a week.
  - Please have your Plan assigned provider ID number ready for ease of identification.
- Call Provider Services to:
  - Inquire about claims, including reprocessing of claims.
  - Request forms or literature.
  - Policy and procedure questions.
  - Report Participant non-compliance.
  - Obtain the name of your Provider Account Executive.

Provider Network Management

Provider Network Management responsibilities include:

- ✓ Building and maintaining a robust network.
- ✓ Contracting with providers.
- ✓ Ensuring that our network covers the full range of covered benefits in an accessible manner for Participants.

In order to meet these responsibilities, Keystone First CHC assigns a Provider **Account Executive** to your office to provide on-site education, issue resolution, and assistance with credentialing.

Secure Provider Portal

NaviNet is an easy-to-use, free, web-based solution that links providers to Keystone First Community HealthChoices. NaviNet delivers:

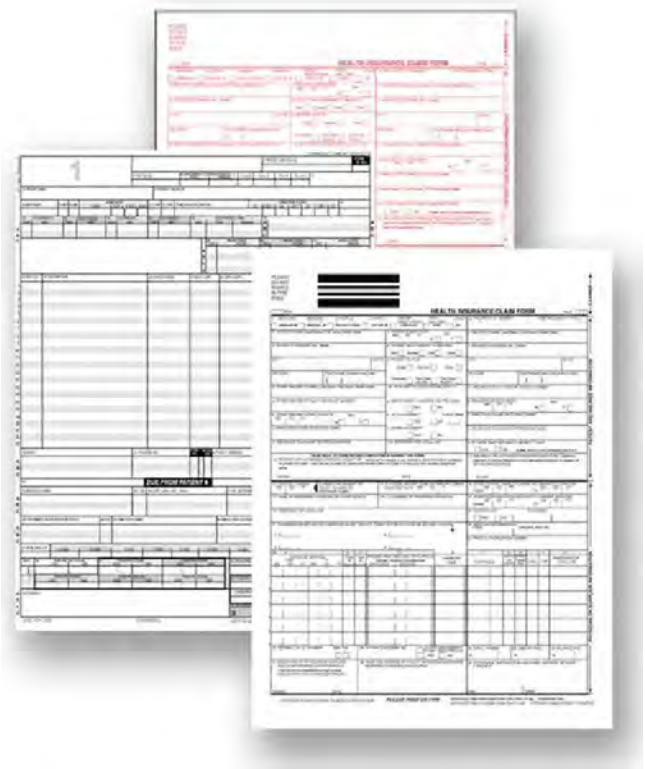
- Secure provider web portal access.
- Increased efficiency for streamlining business processes.
- Reliable access to real-time, paperless transactions.

Log on to www.navinet.net to register for free, fast and easy to use access to:

- Approved authorizations.
- Claim status/Claim investigation/Claim Status Summary Report.
- Enhanced eligibility verification including eligibility history.
- Easy links to provider and Participant materials and resources.

If you are not yet registered, sign up now for your NaviNet account!

Claims and Billing



Keystone First

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Verifying Eligibility

Keystone First Community HealthChoices

Important: Providers are responsible to check eligibility, at a minimum, monthly.

1. PROMISe™

- Go to http://promise.dpw.state.pa.us/ and click on PROMISe Online.
- HIPAA compliant PROMISe software (Provider Electronic Solutions Software) is available free-of-charge.
  - Download from the OMAP PROMISe website at https://promise.dpw.state.pa.us/ePROM/_ProviderSoftware/softwareDownloadForm.asp?m=1

2. Pennsylvania Eligibility Verification System (EVS): 1-800-766-5387, 24 hours/7 days a week

- If a Participant presents to a Provider's office and states he/she is a Medical Assistance recipient, but does not have a PA ACCESS card, eligibility can still be obtained by using the Participant's date of birth (DOB) and Social Security number (SSN) when the call is placed to EVS.
- The plastic "Pennsylvania ACCESS Card" has a magnetic strip designed for swiping through a point-of-sale (POS) device to access eligibility information through EVS.

3. NaviNet: www.navinet.net

- Free, web-based application provides real-time current and past eligibility status and eliminates the need for phone calls to the Plan.

4. Keystone First CHC Automated Eligibility Hotline: 1-800-521-6007

- Provides immediate real-time eligibility status with no holding to speak to a representative.
- Call the Automated Eligibility Hotline 24 hours/7 days a week.

Encounter Data Reporting

- Encounters are defined as “an interaction between an individual and the health care system”.

- Encounters, regardless of compensation method must result in the creation and submission of an encounter record to the Plan via CMS-1500 or 837 format.

- Encounter submission is critical for:
  - ✓ Data that the Plan reports to the Department of Human Services (DHS).
  - ✓ Providing reimbursement for services covered above capitation (if applicable).
  - ✓ Gathering statistical information regarding medical services provided to Participants.
  - ✓ Allows us to identify the severity of illnesses of our Participants.

Claims/billing information and the claims filing guide can be found on our website:
www.keystonefirstchc.com → For Providers → Claims and billing.

Remember…

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- ✓ Any service/product not listed on the Plan fee schedule or services or equipment in excess of limitations set forth by the Department of Human Services fee schedule, benefit limits, and regulation. (Regardless of cost, i.e., above or below the $750 DME threshold) requires prior authorization.
- ✓ Any service(s) **not on the current service plan** performed by non-participating or non-contracted practitioners or providers, unless the service is an emergency service, requires prior authorization.
- ✓ Any service that may be considered experimental and/or investigational requires prior authorization.
- ✓ All miscellaneous/unlisted or not otherwise specified codes requires prior authorization.
- ✓ Prior Authorization is not a guarantee of payment for the service/s authorized. Keystone First CHC reserves the right to adjust any payment made following a review of medical record and determination of medical necessity of services provided.

Claims Filing Timeframes

Claim Type	Filing Timeframes
Original Claims	180 days from the date of service
Resubmission of Denied Claims	365 days from the date of service
Claims involving third party liability	60 days of the date of the primary insurer's explanation of benefits (EOB)

The Plan will not grant exceptions to the claim filing timeframes. Failure to comply with these timeframes will result in the denial of all claims filed after the filing deadline. Late claims paid in error shall not serve as a waiver of the Plan's right to deny any future claims that are filed after the deadlines or as a waiver of the Plan's right to retract payments for any claims paid in error.

Claim Resubmissions

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Electronic submission

Corrected (profession and institutional) claims can be submitted via EDI.

- Resubmit within 365 days of the date of service.

Mail submission

- Mark claim as “Corrected Claim” using **black** ink.
- Mail to claims address with “Corrected Claim” clearly marked on outside of envelope.
- Resubmit within 365 days of the date of service.
- Do not mix corrected claims with new submissions.

Rejected claims definition:

Claims with missing or invalid data elements that do not pass the pre-processing edits are not required to be registered in our claims processing system.

Denied claims definition:

Claims processed through the pre-processing edits and accepted for adjudication but denied for missing or invalid information not billed in accordance to the health plan’s guidelines for proper reimbursement.

Reminder: Providers who use HHAeXchange for billing should follow HHAeXchange billing processes.

Coordination of Benefits (COB)

- **Medicaid** is always the **payer of last resort**.

- May be submitted in both paper and electronic formats.

- Submit claims involving COB within 60 days of receipt of primary carrier's remittance with the following:
  - Claim form.
  - Primary carrier's EOB or denial notification (dates and dollars must match).

- Primary Insurer
  - Must follow requirements for both plans.

Third Party Liability (TPL)

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Sources of TPL

- State file feeds.
- Vendor file feeds.

Manual entry (TPL associates)

- Participant identified.
- Providers identified.
- Internal department identified.

What to do if a TPL denial is received:

- Valid denial (the Plan is not the primary payer).
  - Resubmit claim with EOB electronically or via paper claim.
- Invalid denial (participant does not have other insurance).
  - Resubmit claim with EOB or denial letter.
  - Call Provider Services to report.
  - Instruct Participant to call and update TPL.

Electronic Billing

Electronic Data Interchange (EDI)

- Our EDI payer ID number is **42344**.
- To be set up to bill electronically:
  - Call Change Healthcare at **1-800-845-6592;** or
  - Enroll online at www.changehealthcare.com.

Additional Billing Solutions

Claims submission via ConnectCenter

ConnectCenter is a convenient no-cost claim submission portal available through Keystone First CHC's clearinghouse, Change Healthcare.

Key features of the ConnectCenter portal include:

- Users do not need to choose between data entry of claims and upload of 837 files. All users may do both.
- Secondary and tertiary claims can be submitted.
- Claims created online are fully validated in real time so providers can correct them immediately.
- Remittance advice is automatically linked to a provider's submitted claim, providing a comprehensive view of the status of their claim.

To register as a user, go to ConnectCenter Sign-Up.

Change Healthcare customer support is available through online chat, or call **1-800-527-8133**, **option 2** for assistance.

HHAeXchange

- One **free** system for homecare providers to:
  - Receive authorizations.
  - Communication with the health plan.
  - Perform/transfer EVV.
  - Submit claims.
  - Missed shift reporting.

For more information, contact HHAeXchange at **1-718-407-463**3 or by email at support@hhaexchange.com.

For additional information, visit our website at www.keystonefirstchc.com

Electronic Visit Verification (EVV)

- EVV is an electronic system that verifies when provider visits occur and documents the precise time services begin and end.
- Section 12006 of the 21st Century Cures Act requires all states to implement the use of EVV for Medicaid-funded personal care services (PCS), including respite services, for in-home and community visits by a provider.

  - Keystone First CHC initiated EVV implementation on January 1, 2021 in compliance with all Federal and State requirements.
  - As directed by OLTL, all providers must begin using EVV for PCS and respite services.
  - Providers can select their own vendor or use HHAeXchange.
  - If providers choose to use an alternate vendor, they must send all EVV data to HHAeXchange.
  - All alternate vendor data files must be compliant with OLTL requirements.
  - HHAeXchange submits EVV data to the state aggregator.

To access our EVV overview training, go to: www.keystonefirstchc.com → For Providers → Training

Electronic Funds Transfer (EFT)

- Simplifies the payment process by:
  - ✓ Providing fast, easy and secure payments.
  - ✓ Reducing paper.
  - ✓ Eliminates checks lost in the mail.
  - ✓ Not requiring you to change your preferred banking partner.

- Through **Change Healthcare and ECHO Health, Inc.** providers are offered additional electronic payment methods, including:
  - ✓ Virtual Credit Card (VCC) services.
  - ✓ MedPay.

- For complete information, including enrollment guide, quick reference guide and FAQ, go to our website:

  www.keystonefirstchc.com → Providers → Claims and billing.

- If you previously enrolled in EFT through Change Healthcare, you have been automatically enrolled with ECHO Health.

- If you are not enrolled for EFT:
  - ✓ By default, you will receive payment via VCC.
  - ✓ Contact ECHO Health at **1-888-834-3511** to enroll or with questions.

Electronic Remittance Advice (ERA)

- Keystone First CHC offers ERAs (also referred to as an 835 file) through Change Healthcare and ECHO Health.
- View your remittances online in the ECHO Health provider payments portal, which features enhanced search capabilities.
- To receive ERAs from Change Healthcare and ECHO, you will need to include both the Keystone First CHC payer ID **42344** and the ECHO payer ID **58379**.
- For additional ERA information, including quick reference guide and FAQ, go to our website: www.keystonefirstchc.com → Providers → Claims and billing.
- For ERA enrollment support please contact ECHO Health at **1-888-834-3511**.

Note: Providers that use HHAeXchange for billing and wish to receive ERAs in the HHAeXchange portal, please contact their support team at **1-718-407-4633** or by email at support@hhaexchange.com.

Fraud, Waste, Abuse, and Mandatory Screening Information

Keystone First CHC receives State and Federal funding for payment of services provided to our Participants. In accepting claims payment from our Plans, providers are receiving State and Federal program funds, and are therefore subject to all applicable Federal and/or State laws and regulations relating to this program. Violations of these laws and regulations may be considered fraud* or abuse against the Medical Assistance program. Compliance with Federal laws and regulations is a priority of Keystone First CHC.

Reminders:

- **Complete** the Fraud, Waste, and Abuse training and attestation annually.
- **Screen** employees and contractors, both individuals and entities, for participation exclusion from the Medicare, Medicaid or any other federal health care program.
- **Report** fraud, waste or abuse concerns and incidents immediately.

*An example of provider fraud is billing for services not rendered or not Medically Necessary, such as billing for personal assistance services while a Participant is in an inpatient setting.

For up-to-date Fraud, Waste, and Abuse information on our website, go to: www.keystonefirstchc.com → Providers → Training.

Reporting and Preventing Fraud, Waste, and Abuse

If you, or any entity with which you contract to provide health care services on behalf of our Participants, become concerned about or identifies potential fraud, waste or abuse, **please contact us in any of the following ways**:

- Toll-free Fraud, Waste, and Abuse Hotline: **1-866-833-9718**
- E-mail: FraudTip@amerihealthcaritaschc.com
- Mail a written statement to Special Investigations Unit, Keystone First CHC, P.O. Box 7317, London, KY 40742.

How to report fraud, waste, and/or abuse to the Commonwealth:

- Phone: **1-844-DHS-TIPS** or **1-844-347-8477** | Fax: **1-717-772-4655,** Attn: MA Provider Compliance Hotline
- Online: https://www.dhs.pa.gov/about/Fraud-And-Abuse/Pages/default.aspx
- Mail: Department of Human Services, Office of Administration Bureau of Program Integrity, P.O. Box 2675, Harrisburg, PA 17105-2675

Participant Lock-In Program

- Participants who over-utilize or mis-utilize medical services are eligible for Lock-in.
- The Department of Human Services is solely responsible for restricting Participants.
- Participants may be restricted to obtaining services from a single, designated provider for a fixed period.
- Participants will be subject to subsequent utilization review during the Lock-in period.
- For more information about the Participant Lock-in Program, please reference the Provider Manual.

Resources

- **State Community HealthChoices web page**: http://www.healthchoices.pa.gov/info/about/community/index.htm

- **DHS ListServ - DHS email updates with important CHC information:**
  - http://listserv.dpw.state.pa.us/Scripts/wa.exe?SUBED1=oltl-community-healthchoices&A=1
  - You will receive an email message with a confirmation code will be sent to the address you specify.
  - Simply wait for this message to arrive, then follow the instructions to confirm your subscription.

- **Pennsylvania Department of Aging**: http://www.aging.pa.gov/publications/alzheimers-related-disorders/Pages/default.aspx

- **Suspect elder abuse or abuse of an adult with a disability?** http://www.dhs.pa.gov/citizens/reportabuse/dhsadultprotectiveservices/

- **PA Medicaid Fraud Control Act:** *The Pennsylvania Fraud and Abuse Controls, 62 P.S. §§ 1407, 1408.*

- **Keystone First Community HealthChoices website**: https://www.keystonefirstchc.com

Resources (continued)

Alzheimer's and Dementia Resources
National Alzheimer's and Dementia Resource Center: https://nadrc.acl.gov
Education Programs and Dementia Care Resources: https://www.alz.org/help-support/resources/care-education-resources
2018 NADRC: Handbook for Helping People Living Alone With Dementia Who Have No Known Support: https://nadrc.acl.gov/details?search1=157
National Institute on Aging: https://order.nia.nih.gov/view-all-alzhemer-pubs
Healthy Aging program and resources: https://www.cdc.gov/aging/index.html
Alzheimer's disease and healthy aging: https://www.cdc.gov/aging/aginginfo/alzheimers.htm
Alzheimer's Association — Greater Pennsylvania Chapter: https://www.alz.org/pa 24/7 HELPLINE from the Alzheimer's Association: **1-800-272-3900**
Locate a caregiver support group in your area: https://www.alz.org/events/event_search?etid=2&cid=0

Questions?

Keystone First
Community HealthChoices

Email us at:

CHCProviders@keystonefirstchc.com

Provider Services phone line:

1-800-521-6007

Our website:

www.keystonefirstchc.com

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