AmeriHealth Caritas Pennsylvania (PA) Community HealthChoices (CHC) Provider Orientation
Agenda

Welcome and Introductions
Participant Information
Provider Information
Long-Term Services and Supports
Medicare/Medicaid Dually Eligible Participants
Key Departments and Resources
Prior Authorization and Utilization Management
Provider Disputes and Appeals: Participant Complaints, Grievances and Fair Hearings
Regulations
Critical Incident Reporting
Resources
About AmeriHealth Caritas

AmeriHealth Caritas is part of the Independence Health Group in partnership with Blue Cross Blue Shield of Michigan.

AmeriHealth Caritas is one of the nation’s leaders in health care solutions for those most in need. Operating in 17 states and the District of Columbia, AmeriHealth Caritas serves more than 5.7 million Medicaid, Medicare and Children’s Health Insurance Program (CHIP) Participants through its integrated managed care products, pharmaceutical benefit management and specialty pharmacy services, behavioral health services, and other administrative services.

Headquartered in Philadelphia, with offices in Harrisburg and Pittsburgh, AmeriHealth Caritas is a mission-driven organization with more than 30 years of experience serving low-income and chronically ill populations. For more information, visit www.amerihealthcaritas.com.
AmeriHealth Caritas Pennsylvania (PA) Community HealthChoices (CHC) maintains offices throughout the Commonwealth to support our network providers.

AmeriHealth Caritas PA CHC
8040 Carlson Road
Harrisburg, PA 17112

AmeriHealth Caritas PA CHC
11 Stanwix Street
Pittsburgh, PA 15222

AmeriHealth Caritas PA CHC
200 Stevens Drive
Philadelphia, PA 19113
Our Mission and Values

We help people:

• Get care
• Stay well
• Build healthy communities
Our Values

Advocacy • Care of the Poor • Compassion • Dignity • Diversity • Hospitality • Stewardship
Community HealthChoices (CHC) is Pennsylvania’s mandatory managed care for dual-eligible (Medicaid and Medicare) individuals and individuals with physical disabilities, including long-term services and supports (LTSS) for adults over age 21 in the Office of Long Term Living (OLTL) waivers.

The aim of CHC is to serve more people in communities rather than in facilities, giving them the opportunity to work, spend more time with their families, and experience an overall better quality of life.
Participants 55 years or older who are nursing facility eligible may choose to enroll in CHC or remain in a LIFE program.
How is CHC Similar to HealthChoices?

• Both are **Medicaid managed care programs**.
• **Zones**: Five geographic zones are the same.
• **Choice**: Participants may choose their Managed Care Organization (MCO).
• **Physical health benefits** are the same (Adult Benefit Package).
• **Behavioral health benefits** for both are administered by the Behavioral HealthChoices MCOs.
How is CHC Different from HealthChoices?

- CHC provides coverage for Participants who are eligible for both Medicare and Medicaid (dual-eligible).

- CHC- MCOs can also provide Medicare coverage (called D-SNPs) to Participants who want their Medicaid and Medicare services coordinated by the same entity.  
  - AmeriHealth Caritas VIP Care is the aligned D-SNP for AmeriHealth Caritas PACHC.

- CHC provides long-term services and supports to Participants who need the level of care provided in a nursing home.
Service Counties

CHC has begun to be phased in across the state using the five geographic HealthChoices zones. Affected individuals for Phases 2 and 3 will be notified at least 90 days before CHC begins.

- **Phase One:** January 1, 2018 - Southwest zone
- **Phase Two:** January 1, 2019 - Southeast zone
- **Phase Three:** January 1, 2020 - Northwest, Lehigh/Capital and Northeast zones
Our **multifaceted** approach addresses our Participants’ needs, **connecting** them with the health care and services they need to get well and stay well. Our approach includes:

- Engaging, educating, and empowering Participants to actively participate in improving their health outcomes.
- Providing Participants with the information they need, when they need it, through our use of technology and Participant portals.
- Involving Participants, along with their care team made up of the Participant’s care manager, service coordinator, physicians, service providers, and community and natural supports, in the care planning and management process.
- Using community-based services to appropriately avoid or delay institutional care, supporting Participants who desire to remain in a home- and community-based setting.
- Incentivizing and rewarding healthy Participant-specific behaviors.
Our Pledge

AmeriHealth Caritas PA 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.
Participant Information
Participant Identification Cards

AmeriHealth Caritas PA CHC ID Card

Front

Back

AmeriHealth Caritas VIP Care ID Card

Front

Back

Covered by AmeriHealth Fina.
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;

- 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.
Verifying Eligibility

1. 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.

2. Internet: NaviNet ([www.navinet.net](http://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.
   • For more information or to sign up for access to NaviNet, go to [www.navinet.net](http://www.navinet.net) or call NaviNet Customer Service at 1-888-482-8057.

3. AmeriHealth Caritas PA 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.

4. PROMISe
   • Go to [http://promise.dpw.state.pa.us/](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](https://promise.dpw.state.pa.us/ePROM/_ProviderSoftware/softwareDownloadForm.asp?m=1).
Participant Rights and Responsibilities can be found on the Provider and Participant web pages located on our website at: www.amerihealthcaritaschc.com.

A corresponding AmeriHealth Caritas PA CHC Participant Rights and Responsibilities handout is included in your informational packet.
Physical Health Benefits

AmeriHealth Caritas PA CHC Participants receive the same physical health benefits that are part of the Medicaid Adult Benefit Package, which include but are not limited to:

- Inpatient Hospital Services
- Outpatient Hospital Clinic
- Laboratory and X-Ray Service
- Nursing facility services
- Family Planning
- Physician Services
- Podiatry Services
- Optometrist Services
- Dental

- PT, OT, ST
- Prescription Drugs
- Ambulance Transport
- Non-Emergency Medical Transport
- Chiropractic Services
- Home Health Care
- Durable Medical Equipment
- Medical Supplies
- Hospice
Behavioral Health and Substance Use Benefits

• **Please note:** Under the Community HealthChoices Program, behavioral health services are coordinated through, and provided by, the Participant's BH-MCO.
  - These services are not part of the AmeriHealth Caritas PA CHC benefit package, but are available to all AmeriHealth Caritas PA CHC Participants through the BH-MCOs.

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

• 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](https://www.enrollnow.net/learn/behavioral-health-services).
Participant Co-payments

There are no co-pays for any services, other than a $2 co-pay for prescription brand name drugs.
Emergency Care Definition

An “Emergency Medical Condition" is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy
- Serious impairment to bodily functions (or)
- Serious dysfunction of any bodily organ or part
Emergency Care Policy

• AmeriHealth Caritas PA CHC (the Plan) does not require Prior Authorization or pre-approval of any Emergency Services.

• The Plan PCP and Specialist Office Standards require Network Providers to provide Medically Necessary covered services to Plan Participants, including emergency and/or consultative specialty care services, 24 hours a day, 7 days a week. Participants may contact their PCP for initial assessment of medical emergencies.

• In cases where Emergency Services are needed, Participants are advised to go to the nearest Hospital Emergency Room (ER), where ER staff should immediately screen all Plan Participants and provide appropriate stabilization and/or treatment services.
Medical and Non-Medical Transportation

- The transportation scenarios listed below are a covered benefit:
  - Medically necessary emergency ambulance transportation.
  - Medically necessary non-emergency ambulance transport.
  - Specialized non-emergency medical transportation must be provided for Participants (i.e. Participants who are stretcher-bound).
  - Nursing Facility Clinically Eligible (NFCE) Participants are entitled to non-medical transportation. Non-medical transportation services are:
    - An addition to covered medical transportation services.
    - For LTSS services that are authorized in the Patient-Centered Service Plan (PCSP).

- All other non-emergency transportation for Participants to and from Medicare-covered services and covered services must be arranged through the Medical Assistance Transportation Program (MATP) vendor.

- Some Participants may qualify for non-emergency medical transportation through programs such as Shared Ride.
Medical Assistance Transportation Program (MATP)

The Medical Assistance Transportation Program, also known as MATP, provides transportation to medical appointments for Medicaid recipients who do not have transportation available to them.

The individual’s county of residence will provide the type of transportation that is the least expensive while still meeting their needs.

For more information, log on to http://matp.pa.gov/.
Provider Information
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 Office Standards

Appointment Accessibility Standards – Primary Care Provider (PCP)

• Health assessment/general physical examinations and first examinations must be scheduled within three (3) weeks of the Participant’s Enrollment.

• Routine appointments must be scheduled within ten (10) business days of the Participant’s request.

• Non-Urgent Sick Visits must be scheduled within seventy-two (72) hours of the Participant’s request, as clinically indicated.

• Urgent Medical Condition Care must be scheduled within twenty-four (24) hours of the Participant’s request.

• Emergency Medical Condition Care must be seen immediately or referred to an emergency facility.

Participant’s 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.
Specialist access and appointment standards

Specialist scheduling procedures should ensure:

• Emergency medical condition appointments immediately upon referral.

• Urgent Medical condition care appointments within twenty-four (24) hours of Participant's call.

• Scheduling of appointments for routine care shall be scheduled to occur within thirty (30) days for all specialty Provider types.
Primary Care Practitioner (PCP) Role

- PCPs are the starting point for access to all health care benefits and services.
- PCPs are expected to refer appropriately for both outpatient and inpatient services while continuing to manage the care being delivered.
- PCPs and their office staff support education to Participants that stress they should seek advice from their PCP before accessing care from any other source.
- PCPs play an integral role in Service Planning and should notify the Service Coordinator when there is a change in condition, hospital admission, change in caregiver status and assist in identifying the subtle changes that could prevent an admission to the hospital or nursing facility.
- PCPs and all providers are vital Person-Centered Planning Team (PCPT) members with valuable input to ensure that the Participant successfully meets their goals.
Patient Management by the PCP

✔ Participants should be seen by their PCP every six months.

✔ Discuss and document discussions and wishes regarding advance directives with adult Participants.

✔ PCPs may be requested to submit letters of medical necessity when required.

✔ PCPs may request the transfer of a Participant whose behavior precludes the maintenance of an effective relationship with the PCP.

✔ PCPs may request that their panel be limited or closed – requires 90 day advance written notice.
Medical Care – The Plan Standard:

- After-hours care by a PCP or a covering PCP must be available *24 hours/7 days a week*
- The Plan PCP, or the PCP’s qualified, designated on-call providers, should be accessible 24 hours per day, seven days per week, for urgent or emergency care: at the office site during all published office hours, and by answering service after hours.
- When the PCP uses an answering service or answering machine to intake calls after normal hours, the call must be answered within ten (10) rings, and the following information must be included in the message:
  - Instructions for reaching the PCP
  - Instructions for obtaining emergency care

*All PCPs are required to complete an annual Access to Care survey for Appointment and After Hours Accessibility Standards.*
Specialist Referrals

The PCP can write a prescription, call, send a letter or fax a request to a participating Plan specialist. The referral to the specialist must be documented in the Participant’s medical record. The referring practitioner should communicate all appropriate clinical information directly to the specialist without involving the Participant. Provide the following information:

- Participant name and ID number.
- Reason for referral.
- Duration of care to be provided.
- All relevant medical information.
- Referring practitioner’s name, National Provider Identifier (NPI) and Plan-issued ID number.

**Important note:** The NPI of the ordering, referring or prescribing provider must be included on the rendering provider’s claim to validate the provider’s enrollment in the Pennsylvania MA program.
Provider Incentive Program

Each Provider Incentive Program (PIP) will include a program description containing the following:

- Description of the parties involved in the Program.
- The term of Program including the Program commencement date.
- The pool of incentive dollars available for the Program including the calculation of earned incentives and measurement period covered.
- The Line of Business (LOB) covered in the Program.
- A listing of quality and cost/efficiency measures with available incentive pool dollars available for each measure per §422.208. This will vary based on the structure of the value based model. Health Care Payment Learning Action Network (HCP LAN) might be upside and/or downside.
- A descriptive overview describing how each measure is defined and what is used as the source of the data.
- For each measure a sample calculation summary using baseline and hypothetical data (including the number of Participants where appropriate) displaying the calculations required to establish incentive payments earned (if any).
- The entity to which payment (if any) will be made and the period in which the payment will be made.
- A dispute resolution process.
- A statement reflecting that the Program contains no incentive to reduce or limit medically necessary care and services. The Parties shall mutually acknowledge and affirm that nothing in the Provider Incentive Program is intended as an inducement or incentive to reduce or limit medically necessary services furnished to Participants per§422.208 (c) (1). – All incentives are designed to focus on quality improvements. – Any quantitative measures that are used are related to preventables.* *Preventables are admissions/visits that with the proper care could have been avoided.
Long-Term Services and Supports
Nursing Facility Clinically Eligible (NFCE)

- NFCE is defined as having clinical needs that require a level of care provided in a nursing facility and includes:
  - Participants who are eligible to receive home- and community-based services (HCBS) in the community; or
  - Participants who currently reside in a Nursing Facility

- Must be over 21 years of age.
- Must meet the criteria for Nursing Facility level of care.
Long-term Support Services

- Adult Daily Living
- Assistive Technology
- Benefits Counseling
- Career Assessment
- Community Integration
- Community Transition Services
- Employment Skills Development
- Exceptional DME
- Financial Management Services
- Home Adaptations
- Home Delivered Meals
- Home Health Services
- Job Coaching
- Job Finding
- Non-Medical Transportation
- Nursing Facility Services
- Participant-Directed Community Supports
- Participant-Directed Goods and Services
- Personal Assistance Services
- Personal Emergency Response System
- Pest Eradication
- Residential Habilitation
- Respite
- Specialized Medical Equipment and Supplies
- Structured Day Habilitation
- TeleCare
- Therapeutic and Counseling Services
- Vehicle Modification

All LTSS services are designed to support the Participant in living independently and remaining as engaged in his or her community as possible.
LTSS Service Coordination

- AmeriHealth Caritas PA CHC will **facilitate and coordinate** 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 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.
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.
Nursing Facility Clinically Eligible Assessment Process

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

The Department of Human Services (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 Managed Care Organizations.

**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.

**AmeriHealth Caritas PA CHC** will refer individuals who are identified as potentially eligible for LTSS to DHS or its designee for level of care determination, if applicable.
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.
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.
Person-Centered Service Plan (PCSP)

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.
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 he 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 PCPT meetings.
Participant Self-Directed Services

Participants who are eligible have the opportunity to self-direct Personal Assistance Services (PAS) and Respite through one of two models.

1. Participants may elect to receive PAS through a Participant-Directed Employer Authority model. The Participant employs his or her own personal assistance provider which can be a family member, a friend, a neighbor or any other qualified personal assistance worker*; or

2. Participants may elect the Budget Authority model called Services My Way, in which the PCSP is converted to a budget and the Participant develops a spending plan to purchase needed goods and services. Participants in this model may elect to receive personal assistance through an agency and/or to employ their own personal assistance providers.

* The personal assistance worker cannot be the Participant’s Power of Attorney, Spouse, or Life Insurance beneficiary.
Participants in Nursing Facilities

- Participants are permitted to remain in their current facility regardless of provider contracting status.
- Contact with non-contracted facilities will continue to encourage contracting to expand Participant choice for providers.
- Preadmission screening and resident review coordination and compliance will be maintained as required.
- Participants are given a choice of Service Coordinators but all Nursing Facilities will have a single point of contact to address admissions, billing, and service plan concerns.
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.

- Existing service plans - all services currently authorized will continue on January 1, 2020 through the continuation of care (COC) period or reassessment and a new plan put in place.

For prior authorization, call Utilization Management at: 1-800-521-6622.
Medicare and Medicaid Dual Eligible Participants
Nursing Facility Ineligible

Nursing Facility ineligible (NFI) is defined as having clinical needs that do not require a level of care provided in a nursing facility. NFI Participants include:

- 21 years of age.
- Community Well Duals (CWD).
- Medicare/Medicaid.
- May be aligned DSNP, unaligned DSNP, or Fee-for-Service (FFS).
- Have the adult medical benefits in selected/assigned Plan’s CHC package.
- Not eligible for the LTSS benefits.
- Will be screened on enrollment for unmet needs.
- Will receive active care coordination during acute/episodic changes in health.
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.

- 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

• The goal of AmeriHealth Caritas PA CHC and its companion D-SNP (AmeriHealth Caritas 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.

• AmeriHealth Caritas PA CHC will cooperate fully with DHS and 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

- AmeriHealth Caritas PA CHC 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 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.
Key Departments and Resources

- Provider Network Management
- Provider Services
- Credentialing and Re-credentialing
- Claims and Billing
- Prior Authorization
- Utilization Management
- Pharmacy
- Secure Provider Portal
Provider Network Management

AmeriHealth Caritas PA CHC assigns a Provider **Account Executive** to your office to provide on-site education, issue resolution, assistance with credentialing.

Provider Network Management responsibilities include:

- Building and maintaining a robust network.
- Contracting with hospitals, physicians, and ancillary providers.
- Ensuring that our network covers the full range of covered benefits in an accessible manner for Participants.
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 ensure all Network Providers receive the highest level of service available.

- Phone **1-800-521-6007**, 24 hours/7 days a week.
- Call Provider Services to:
  - Request forms or literature.
  - Policy and procedure questions.
  - Inquire about claims.
  - Report Participant non-compliance.
  - Obtain the name of your Provider Account Executive.
  - Request access to centralized services such as:
    - Outpatient laboratory services
    - Behavioral Health services
    - Dental services
    - Vision services
LTSS Credentialing

LTSS providers

• Application for Home-and Community-Based Services (HCBS)/LTSS providers is found on our website at www.amerihealthcaritaschc.com

• Completed forms can be faxed to the Credentialing Department at 1-717-651-1673 or emailed to provider.credentialinghbg@amerihealthcaritaspa.com (medical providers) and CHCProviders@Amerihealthcaritas.com (LTSS providers).

• Active enrollment with Pennsylvania Medical Assistance by location and Medicare (as applicable) is required.

• Revalidation requests must be completed in order to remain active with AmeriHealth Caritas PA CHC.

• LTSS providers are re-credentialed every three years.
Ordering, Referring, Prescribing Process

AmeriHealth Caritas PA CHC is required to comply with requirements outlined by the Affordable Care Act (ACA) §42 CFR 455 and the Pennsylvania Department of Human Services (DHS) that providers, including those who order, refer or prescribe items or services for AmeriHealth Caritas PA CHC Participants, must be enrolled in the Pennsylvania Medical Assistance (MA) Program.

AmeriHealth Caritas PA CHC will use the NPI of the ordering, referring or prescribing provider included on the rendering provider’s claim to validate the provider’s enrollment in the Pennsylvania MA program.

A claim submitted by the rendering provider will be denied if it is submitted without the ordering/prescribing/referring provider’s Pennsylvania MA enrolled Provider’s NPI, or if the NPI does not match that of a Pennsylvania enrolled MA provider.

If you need to enroll as a MA Provider:

- Go to the following website for enrollment information through DHS: http://www.dhs.pa.gov/provider/promiSe/enrollmentinformation/S_001994
- All providers must revalidate their MA enrollment every 5 years.
- Providers should log into PROMISe™ to check their revalidation date and submit a revalidation application to DHS at least 60 days prior.
- Enrollment (revalidation) applications can be found at: https://promise.dpw.state.pa.us/portal/Default.aspx?alias=promise.dpw.state.pa.us/portal/provider
Prior Authorization and Utilization Management
Prior Authorization

- Elective inpatient hospital admissions, including rehabilitation
- Elective transplant evaluations and procedures
- Elective/non-emergent air ambulance transportation
- Elective transfers for inpatient or outpatient services between acute care facilities
- Skilled nursing facility
- Gastroenterology services (code 91110 and 91111 only)
- Bariatric surgery
- Prior authorization is required for all pain management services, with the exception of:
  - Services that are on the Pennsylvania Medical Assistance (PA MA) fee schedule and are provided in a participating physician office setting (POS 11).
- Cosmetic procedures
- PT, OT, ST exceeding 24 visits per discipline within a calendar year
- Home health services after 6 visits per modality performed in a calendar year (may not exceed 60 visits)
- Shift care/private duty nursing
- LTSS Services (Home and Community-Based and Custodial Nursing Facility)
- DME-rentals and purchases in excess of $750 per item in billed charges
- Wheelchair purchases and accessories, regardless of cost
- Enterals:
  - Prior authorization is required for Participants over age 21.
  - Prior authorization is required when the request is in excess of $200/month for Participants under age 21.
Prior Authorization, continued

- Diapers—any request in excess of 300 diaper or pull-ups (or combination), requests for brand-specific diapers
- Cardiac or pulmonary rehabilitation
- Chiropractic services after initial visit
- Any service performed by a non-participating provider, unless it is an emergency service
- Experimental or investigational services
- Neurological Psychological testing
- Genetic laboratory testing
- All miscellaneous/unlisted codes
- Services or equipment not on MA fee schedule and/or in excess of DHS limitations
- Ambulance transportation to and from a PPEC/medical daycare
- Select prescription medications
- Select dental services
- Elective termination of pregnancy

For prior authorization, call Utilization Management at **1-800-521-6622**.
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.

- Existing service plans - all services currently authorized will continue on January 1, 2020 through the continuation of care (COC) period or reassessment and a new plan put in place.

For prior authorization call
Utilization Management at: 1-800-521-6622
Remember...

- 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. AmeriHealth Caritas PA CHC reserves the right to adjust any payment made following a review of medical record and determination of medical necessity of services provided.
Utilization Management

Telephone: 1-800-521-6622

Prior Authorization Fax: 1-866-755-9949

Inpatient Notification Fax: 1-855-332-0991

• Monday to Friday, 8:00 am to 5:00 pm.

• Prior Authorization

• Admission Notification

• Jiva (OB auth)

  1. NaviNet Access

  2. Internet Explorer 11
Pharmacy

• The Pharmacy Services Department is responsible for all administrative, operational and clinical functions associated with providing participants with a comprehensive pharmacy benefit*

• Covered services are those related to dispensing prescription and OTC drugs in accordance with the participant’s benefit plan and the Pennsylvania Medical Assistance Program.
  o Note: For Medicare primary Participants, refer to the Participant’s Medicare Part D plan.

• Select prescription medications require prior authorization.
  o For information on which prescription drugs require authorization, see the Plan’s Formulary at www.amerihealthcaritaschc.com.

*There may be benefit limits or co-payments associated with this service.
Pharmacy, continued

Pharmacy prior authorization requests can be submitted online. Go to www.amerihealthcaritaschc.com and submit the online prior authorization request form that, when completed, submits pharmacy prior authorization requests instantly!

Prior Authorization is required for all prescriptions on multi-source branded products, injectables, and non-formulary medications.

• For pharmacy authorization Fax: 855-851-4058
• For billing/payment inquiries Call: 888-674-8720
• Peer-to-peer pharmacy requests Call: 888-674-8720
• After business hours, weekends and holidays call Participant Services at 855-235-5115.
Pharmacy, continued

National Drug Code (NDC) Requirements

All claims for outpatient medications are validated for the presence of a(n):

1. Valid NDC.
2. NDC that corresponds to the billed Healthcare Common Procedure Coding System (HCPCS) code.
3. Accurate unit of measure on the NDC bill (F2, GR, ML, UN)
4. NDC quantity with appropriate FDA minimum and maximum levels.

Claims submitted that do not meet all of the above-listed validation criteria will be denied.

Secure provider portal

**NaviNet**

Want to know more about a Participant’s condition or what tests or procedures they have or have not received? NaviNet can give you those answers and more!

Log on to [www.navinet.net](http://www.navinet.net) to register for free, fast and easy to use access to the following information:

- Care Gaps Alerts.
- Claim Status/Claim Status Summary Report.
- Discharge Summary.
- Enhanced Eligibility including Eligibility History.
- Participant Clinical Summary.
- Panel Roster.
Bright Start Maternity Unit

- Care Coordinators outreach to high-risk pregnant participants to coordinate care and address various issues throughout pregnancy and postpartum, including dental and depression screening.

- Call Bright Start at: 1-877-364-6797.

- Participants may self-refer for OB care.

- Bill an appropriate office visit code with a pregnancy diagnosis in addition to T1001-U9.

- OB Care Providers must complete an Obstetrical Needs Assessment Form (ONAF) and either submit electronically through the Optum OB Care website at obcare.optum.com or via fax to 1-866-405-7946 within seven calendar days of the date of the prenatal visit as indicated on the form.

- ONAF forms not meeting the seven calendar day submission requirement will not be reimbursed for T1001-U9.

- Diagnostic tests and pregnancy-related services, such as ultra sound, non-stress tests, childbirth education, and smoking cessation counseling, do not require a referral.
Claims and Billing
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, UB-04 or 837 format.

- Encounter submission is critical for:
  - Data that the Plan reports to 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.
Electronic Billing/EDI

Electronic Data Interchange (EDI)

• Our EDI payer ID number is **77062**.

• To be set up to bill electronically:
  ➢ Call Change Healthcare at **1-800-845-6592**; or
  ➢ Enroll online at [www.changehealthcare.com](http://www.changehealthcare.com).
# Claims Filing Deadlines

<table>
<thead>
<tr>
<th>Claim Type</th>
<th>Filing Timeframes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Original Claims</td>
<td>180 days from the date of service</td>
</tr>
<tr>
<td>Resubmission of Denied Claims</td>
<td>365 days from the date of service</td>
</tr>
<tr>
<td>Claims involving third party liability</td>
<td>60 days of the date of the primary insurer’s EOB</td>
</tr>
</tbody>
</table>

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

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.
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 Explanation of Benefits (EOB) or Denial Notification (dates and dollars must match).

- Primary Insurer
  - Must follow requirements for both plans.
Third Party Liability

Sources of Third Party Liability (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 explanation of benefit (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.
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:

AmeriHealth Caritas PA CHC
Claims Disputes
P.O. Box 7110
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
Additional Billing Solutions

Change Healthcare *Provider WebConnect* – Direct Claim Entry

- Provider WebConnect is a **free**, direct claim entry function through AmeriHealth Caritas PA CHC’s clearinghouse, Change Healthcare.
- Assists small to medium sized practices in reducing costs while improving your overall office workflow.
- Enables your practice to manually enter CMS-1500 claims data that will be electronically submitted to AmeriHealth Caritas PA CHC.

For more information, visit our website at [www.amerihealthcaritaschc.com](http://www.amerihealthcaritaschc.com).

HHAeXchange

- One **free** system for homecare providers to:
  - Receive Authorizations
  - Communicate
  - Perform/Transfer EVV
  - Bill

- Providers attend one training with breakouts for each individual plan’s presentation and joint HHAeXchange system training.
Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA)

EFT and ERA

- 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

- Enroll through Change Healthcare at www.changehealthcare.com

- Call Change Healthcare customer service to sign up for EFT/ERA at 1-800-845-6592.
Electronic Remittance Advice

• View your remittances online in the Change Healthcare website, which features enhanced search capabilities.

• Change Healthcare's Payment Manager offers user friendly, web-based tools for viewing electronic and paper remittances and payments, and is also a centralized location for storage and retrieval of remittances and payment data.
PROVIDER DISPUTES AND APPEALS: PARTICIPANT COMPLAINTS, GRIEVANCES, AND FAIR HEARINGS
Provider Disputes and Appeals

A Provider **Dispute** is a written expression of dissatisfaction by a Network Provider regarding an AmeriHealth Caritas PA 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**, including failure by the Plan to return a Provider’s calls, frequency of site visits by the Plan’s Provider Account Executives and lack of Provider Network orientation/education by the Plan.

- **Issues with the Plan processes**, including failure to notify Network Providers of policy changes, dissatisfaction with the Plan’s Prior Authorization process, dissatisfaction with the Plan’s referral process and dissatisfaction with the Plan’s Formal Provider Appeals Process.

- **Contracting issues**, including dissatisfaction with the Plan’s reimbursement rate, incorrect payments paid to the Network Provider and incorrect information regarding the Network Provider in the Plan’s Provider database.
Provider Disputes and Appeals

For Provider Disputes not concerning medical necessity, just call Provider Services at 1-800-521-6007.

You can also mail provider disputes to:

AmeriHealth Caritas PA CHC
Informal Provider Disputes
P.O. Box 7110
London, KY 40742 - 7146

• The Plan will investigate, conduct an on-site meeting with the Network Provider (if one was 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.amerihealthcaritaschc.com.
Provider Disputes and 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. The two (2) types of issues that may be addressed through the Formal Provider Appeals Process are:

- Disputes not resolved to the Network Provider’s satisfaction through the Plan’s Informal Provider Dispute Process
- Denials for services already rendered by the Provider to a Participant including denials that:
  1. 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**
  2. 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 this Section of the Manual for required elements of a Participant consent for a Grievance.) **Note: these requirements do not apply to Complaints.**
Provider Disputes and Appeals

Written request for the reversal of a medical denial:

Inpatient Appeals
AmeriHealth Caritas PA CHC
P.O. Box 80111
London, KY 40742-0111

Outpatient Appeals
AmeriHealth Caritas PA CHC
P.O. Box 80113
London, KY 40742-0113
Participant Complaints, Grievances and Fair Hearings**

** Refer to the Provider Manual for complete detailed information on Participant Complaints, Grievances and Fair Hearing rules, procedures and timeframes.

**Complaints**

A **Complaint** is a dispute or objection regarding a participating Health Care Provider or the coverage, operations, or management of the Plan, which has not been resolved by the Plan and has been filed with the Plan or with Department of Health (DOH) or Pennsylvania Insurance Department (PID), including but not limited to:

- The denial because the requested service or item is not a Covered Service;
- The failure of the CHC-MCO or Plan to provide a service or item in a timely manner, as defined by the Department;
- The failure of the CHC-MCO or Plan to decide a Complaint or Grievance within the specified time frames;
- The denial of payment by the Plan 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;
- The denial of payment by the Plan after a service or item has been delivered because the service or item provided is not a Covered Service for the Participant; or
- The 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.

**First level Complaints**

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:

a. The denial because the service or item is not a Covered Service;
Participant Complaints, Grievances and Fair Hearings

b. The failure of the Plan to provide a service or item in a timely manner, as defined by the Department;

c. the failure of the Plan to decide a Complaint or Grievance within the specified time frames;

d. 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;

e. 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

f. 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.

• The Plan must send a written notice of the first level Complaint decision 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.

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

• For certain situations, 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 Plan’s first level Complaint decision. Refer to Section VIII of the Provider Manual for complete detailed information on Participant Complaints, Grievances and Fair Hearing rules, procedures and timeframes.
Participant Complaints, Grievances and Fair Hearings

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 Plan’s first level Complaint decision.

**Second Level Complaints**

Participants 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 Member’s behalf, may file a second level Complaint either in writing or orally for any Complaint for which a Fair Hearing and external review is not available.

- The Plan will 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.

- 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 Plan’s second level Complaint decision.

**External Complaints**

1. 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 post-marked within **ten (10) days** from the mail date on the written notice of the Plan’s first or second level Complaint decision.
Participant Complaints, Grievances and Fair Hearings

2. Upon the request of either DOH or PID, the Plan will transmit all records from the Plan’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 Plan may submit additional materials related to the Complaint.

3. DOH and PID will determine the appropriate agency for the review.

**Expedited Complaints**

The Plan will conduct expedited review of a Complaint if the Plan 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 Plan 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.

• The Plan will 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 Plan 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.

• 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 Plan’s expedited Complaint decision.

• 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 Plan within **two (2) business days** from the date the
Participant Complaints, Grievances and Fair Hearings

• A request for expedited review of a Grievance may be filed either in writing, by fax, by email, or orally.

• The expedited review process is bound by the same rules and procedures as the Grievance review process with the exception of timeframes.

• The Plan 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 Plan 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.

• 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 Plan’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 Plan within **two (2) business days** from the date the Participant receives the Plan’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.

• A request for an expedited external Grievance review may be filed in writing, by fax, orally, or by email.
Participant Complaints, Grievances and Fair Hearings

**Fair Hearing Process**

**Fair Hearing** is defined as a hearing conducted by the Department’s Bureau of Hearings and Appeals (BHA) or a Department designee. A Participant must file a Complaint or Grievance with the Plan and receive a decision on the Complaint or Grievance before filing a request for a Fair Hearing. If the Plan fails to provide written notice of a Complaint or Grievance decision within the time frames specified by the Department, the Member is deemed to have exhausted the Complaint or Grievance process and may request a Fair Hearing.

- 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 Plan’s first level Complaint decision or Grievance decision for any of the following:
  
  a. the denial, in whole or part, of payment for a requested service or item based on lack of Medical Necessity;
  
  b. the denial of a requested service or item because the service or item is not a Covered Service;
  
  c. the reduction, suspension, or termination of a previously authorized service or item;
  
  d. the denial of a requested service or item but approval of an alternative service or item;
  
  e. the failure of the Plan to provide a service or item in a timely manner, as defined by the Department;
  
  f. the failure of a Plan to decide a Complaint or Grievance within the specified time frames;
  
  g. 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;
  
  h. 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;
  
  i. the denial of a Participant’s request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other Participant financial liabilities.
Participant Complaints, Grievances and Fair Hearings

• 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 Plan failed to provide written notice of the Complaint or Grievance decision within the time frames specified by the Department.

• BHA will issue an adjudication within ninety (90) days of the date the Participant filed the first level Complaint or the Grievance with the Plan, not including the number of days before the Participant requested the Fair Hearing.

**Expedited Fair Hearing**

• A Participant or the Participant’s representative may file a request for an expedited Fair Hearing with the Department either in writing or orally.

• A Participant must exhaust the Complaint or Grievance process prior to filing a request for an expedited Fair Hearing.

• 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.

• 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.

**Note:** The Pennsylvania Department of Health has developed a standard Enrollee (Participant) consent form that complies with the provisions of Act 68. The form can be found at under "Provider Initiated Grievance and Enrollee Consent Form" on the Pennsylvania Department of Health website or in Appendix VI of the Provider Manual.
Participant Complaints, Grievances and Fair Hearings

Participant receives the Plan’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.

- A request for an expedited external Complaint review may be filed in writing, by fax, orally, or by email.
- The Plan will follow DOH guidelines relating to submission of requests for expedited external Complaint reviews.

Grievance Process

Grievance is defined as a request to have a Plan or utilization review entity reconsider a decision concerning the Medical Necessity and appropriateness of a Covered Service. A Grievance may be filed regarding a Plan’s decision to 1) deny, in whole or in part, payment for a service or item; 2) 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; 3) reduce, suspend, or terminate a previously authorized service or item; 4) deny the requested service or item but approve an alternative service or item; and 5) deny a request for a BLE.

The term does not include a Complaint.

The Plan will 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.

- A Participant must file a Grievance within sixty (60) days from the date the Participant receives written notice of decision.
- 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 post-marked within ten (10) days from the mail date on the written notice of decision.
- The Plan will send a written notice of the Grievance decision to the Participant, Participant’s representative, if the
Participant Complaints, Grievances and Fair Hearings

Participant has designated one in writing, service Provider and prescribing Provider, if applicable, within **thirty (30) days** from the date the Plan 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.

- 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 Plan’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 Plan 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 Plan’s Grievance decision.

**External Grievance Process:**

The Plan will process all requests for external Grievance review. The Plan will 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.

- 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 post-marked within **ten (10) days** from the mail date on the written notice of the Plan’s Grievance decision.

- The Plan will 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 Plan must transmit this information within **fifteen (15) days** from receipt of the Participant’s request for an external Grievance review.

- Within **fifteen (15) days** from receipt of the request for an external Grievance review by the Plan, 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 Plan so that the Plan has an opportunity to consider the additional information.

- 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 Plan, 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.

- 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.

**Expedited Grievance Process**

The Plan must conduct expedited review of a Grievance if the Plan 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 Plan 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.
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 AmeriHealth Caritas PA CHC is for our 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
  - Member Experience Surveys (CAHPS)
  - Measurements /Standards (HEDIS)
  - Clinical Case Reviews

• We will post our QI Program Evaluation annually on our website at: http://www.amerihealthcaritaschc.com
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:
    • Re-education of Provider
    • Process Improvement
    • Corrective action plan for serious or repetitive incidents
  – Follow-up with Provider by AmeriHealth Caritas PA CHC:
    • Medical Director
    • Quality Specialist
    • Provider Services Account Executive

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

• Title III of the American with Disabilities Act (ADA) states that public accommodations, including healthcare provider sites must comply with basic non-discrimination requirements that prohibit exclusion, segregation, and unequal treatment of any person with a disability.

• Racial, ethnic, linguistic, gender, sexual orientation, gender identity and cultural difference 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 when referring to and speaking with people with disabilities, and to understand communication, transportation, scheduling, structural, and attitudinal barriers to accessing services.
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, 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 1-855-235-5115; TTY/TDD 1-855-235-5112 24 hours a day, 7 days a week.
Language Service Associates

Interpreting by Telephone (IBT)
Instant Communication. Total Understanding.
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 telephonic 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
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
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.

Video Remote Interpreting (VRI)
Experience the Power of Clear, Effective and Instantaneous Real-Time Video Communication.
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)
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
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.
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

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.
Americans with Disabilities Act (ADA)

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.
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.
Inspections will be conducted of the office of any Provider who provides services on site at the Provider’s location and who seeks to participate in the Provider Network to determine whether the office is architecturally accessible to persons with mobility impairments.

Architectural accessibility means compliance with ADA accessibility guidelines with reference to parking (if any), path of travel to an entrance, and the entrance to both the building and the office of the Provider, if different from the building entrance.
Critical Incident Reporting

Network Providers and Subcontractors must report critical incidents via the Department’s Enterprise Incident Management (EIM) System.

AmeriHealth Caritas PA 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, except in certain cases, such as hospital stays that were planned in advance.
- 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

- 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.
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 at:
http://www.dhs.pa.gov/provider/longtermcarecasemixinformation/eim
Provider Preventable Conditions/ Preventable Serious Adverse Events (PSAE)

**Network Providers are required to:**

- Identify provider preventable conditions as defined in 42 C.F.R. § 447.26
- Notify AmeriHealth Caritas PA CHC of all acquired PSAE (unless the condition existed prior to the initiation of treatment for the patient).
- AmeriHealth Caritas PA CHC will not pay for PSAE.

Office of Long-Term Living Preventable Serious Adverse Event (PSAE) Provider Reporting Guide

http://www.dhs.state.pa.us/cs/groups/webcontent/documents/document/c_101648.pdf
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.
False Claims Act

The Federal False Claims Act (FCA) is a Federal law that applies to fraud involving any contract or program that is federally funded, including Medicare and Medicaid. It prohibits knowingly presenting (or causing to be presented) a false or fraudulent claim to the federal government or its contractors, including state Medicaid agencies, for payment or approval.

The FCA also prohibits knowingly making or using (or causing to be made or used) a false record or statement to get a false or fraudulent claim paid or approved. Health care entities that violate the Federal FCA can be subject to imprisonment and civil monetary penalties ranging from $5,000 to $11,000 for each false claim submitted to the United States government or its contractors, including state Medicaid agencies, as well as possible exclusion from Federal Government health care programs.
Reporting and Preventing Fraud, Waste and Abuse

AmeriHealth Caritas PA 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 AmeriHealth Caritas PA CHC.

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, AmeriHealth Caritas CHC, 200 Stevens Drive, Philadelphia, PA, 19113.

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

- Phone: 1-844-DHS-TIPS or 1-844-347-8477 Fax: 1-717-214-1200 Attn: OMAP Provider
- Online: www.dhs.pa.gov
- Mail: Bureau of Program Integrity, OMAP Provider Compliance Hotline, PO Box 2675, Harrisburg, PA 17105-2675
Fraud, Waste and Abuse Employee Screening

All providers who participate in Medicare, Medicaid or any other federal health care program are required to screen their employees and contractors, both individuals and entities, to determine if they have been excluded from participation in any of the aforementioned programs.

Resources

- State website for information on Community HealthChoices:
  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/
  - Click on the link for the list you would like to subscribe to.
  - Click on "Join the list."
  - Put in your name and email address.
  - Choose your subscription type, mail header style and acknowledgements.
  - Click "Join [NAME OF LISTSERV]" button.
  - You will receive a confirmation email in which you will have to follow the directions 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/

- Alzheimer’s Association-Greater Pennsylvania Chapter, for provider, Participant and caregiver education, toolkits and resources to help families and individuals understand and live with Alzheimer's, dementia and related disorders:
  http://www.alz.org/pa/

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

Alzheimer’s disease and dementia resources

The resources below can be used by providers and individuals living with Alzheimer’s disease and other dementias, their families and caregivers to better understand the disease and make care decisions together.

**National Alzheimer’s and Dementia Resource Center:** [https://nadrc.acl.gov/](https://nadrc.acl.gov/)

**2018 NADRC: Handbook for Helping People Living Alone with Dementia Who Have No Known Support**

**National Institute on Aging:** [https://order.nia.nih.gov/view-all-alzheimer-pubs](https://order.nia.nih.gov/view-all-alzheimer-pubs)

**Alzheimer’s Association - Greater Pennsylvania Chapter:** [https://www.alz.org/pa](https://www.alz.org/pa)

**Healthy Aging Program and resources:** [https://www.cdc.gov/aging/index.html](https://www.cdc.gov/aging/index.html)

**Alzheimer’s disease and healthy aging:** [https://www.cdc.gov/aging/aginginfo/alzheimers.htm](https://www.cdc.gov/aging/aginginfo/alzheimers.htm)

**Alzheimer’s Association - Greater Pennsylvania Chapter:** [https://www.alz.org/pa](https://www.alz.org/pa)

**24/7 HELPLINE from the Alzheimer’s Association:** 800-272-3900

**Locate a caregiver support group in your local geographic area:** [https://www.alz.org/local_resources/find_your_local_chapter](https://www.alz.org/local_resources/find_your_local_chapter)
Alzheimer’s Resources Continued

2018 NADRC: Education Resources for Persons Living with Dementia and Family Caregivers

This handbook, published by the National Alzheimer’s and Dementia Resource Center, includes links to web pages, message boards, blogs, and videos to assist people living with dementia and family caregivers as they navigate changes in cognition and ability to manage daily activities. The education resources were reviewed by the National Alzheimer’s and Dementia Resource Center. They are free of charge and come from a variety of sources, including government, academia, government-funded Alzheimer’s disease centers, and nonprofit organizations dedicated to Alzheimer’s disease and related disorders. (NADRC)
Questions?

Email us at:

providercommunicationschc@amerihealthcaritas.com

Our website:

www.amerihealthcaritaschc.com
Thank you!