Home- and Community-Based Services (HCBS) Provider Education Webinar

January 2025

Keystone First

Community HealthChoices

Delivering the Next **Generation** of Health Care

What We Are Going to Cover Today

- Service Coordination
- Quality Management
- Provider Services
- Claims and Billing
- Fraud, Waste and Abuse

The presentation is available on our website at www.keystonefirstchc.com → For Providers → Training.

Service Coordination

Service Coordination

- Keystone First Community HealthChoices (CHC) **facilitates and coordinates** Participants' access to all necessary covered services including Medicaid, Medicare, Behavioral Health, and other services, including accessing public benefits and community resources.
- 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 long-term services and supports (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.

Ongoing Support of our Participants

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Social Determinants of Health (SDOH)

Our Person-Centered Service Plan (PCSP) now includes optional completion of the Centers for Medicare and Medicaid Services (CMS) approved SDOH Questionnaire; goals and services can be incorporated into the PCSP based on SDOH Questionnaire responses, including:

- SNAP benefit enrollment support.
- Home delivered meals.
- Non-medical transportation.
- Enrollment in Complex Care Management.

Employment support services

- Initiatives are underway to establish “Employment Champions” as subject matter experts on employment services and resources available in Pennsylvania.
- Working to tie Employment-related goals with authorized services.

Ongoing Support of our Participants (continued)

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Participant support in services that matter to them

- As part of our CAHPS® (Consumer Assessment of Healthcare Providers and Systems) work plan, we seek to better understand what Participants would like to incorporate into their PCSP.
- We are developing an "Explanation of Benefits" video to assist Participants in fully orienting them to the CHC program to help enable them to fully understand all benefits available to them as part of the LTSS benefit package, as well as their Rights and Responsibilities for participation in the program.

Provider Role in Service Planning

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- 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, or change in caregiver status (trigger events) is crucial.

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

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

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

Communicating with Service Coordinators

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

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

Communication with Service Coordinators (continued)

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Direct Service Providers can play an important role in notifying Service Coordinators of a Participant's unplanned hospitalization.

- Within two days of an inpatient stay, Service Coordinators are responsible for working with the Participant, caregivers, and hospital personnel regarding discharge planning.
- Make it a practice to always notify the Service Coordinator that a Participant has been hospitalized.

Missed Shift Reporting

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Please use correct reason codes for reporting missed shifts:

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

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

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

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

Prior Authorization

All LTSS services require prior authorization.

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

The Provider Manual can be found on our website at

www.keystonefirstchc.com → For Providers → Provider manual and forms.

Quality Management

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.

- The goal is to improve Participant outcomes through:
  - Continuity of care.
  - Care coordination.
  - Access to care.
  - Decreased disparity in healthcare.
  - Disease management.
  - Decrease in medical errors.
  - Improved overall health outcomes.
  - Participant satisfaction with health care delivery.

Participant Quality of Care

- Our goal at Keystone First CHC is for 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.
  - Participant experience surveys (**CAHPS®:** Consumer Assessment of Healthcare Providers and Systems).
  - Measurements /standards (**HEDIS®**: Healthcare Effectiveness Data and Information Set).
  - Clinical case reviews.

Quality of Care Review Process

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

- Quality of Care cases are assigned to a Quality Specialist who will:
  - Document incident in data base.
  - Investigate circumstances surrounding incident.
  - Make recommendations for:
    - Provider re-education.
    - Process improvement.
    - Corrective action plan for serious or repetitive incidents.

- Medical Director will determine the final decision for each case.

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

Enterprise Incident Management (EIM)

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 the Home and Community Services Information System (HCSIS), as they do today, for managing Participant information, Provider details, service plans and case management activities. EIM integrates with HCSIS to gather individual and provider information for use in incident reports.

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

Critical Incident Reporting

Network Providers and Subcontractors must report critical incidents via the Department's Enterprise Incident Management (EIM) System, as well as inform the Participant's Service Coordinator. **The entity that first discovers or learns of the critical incident (even if they are not present when it occurs) is responsible to report it.**

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

Network Providers and Subcontractors working with CHC Participants EIM Access:

- Use the same User ID for all CHC Participants, regardless of their MCO enrollment.
- For EIM system access contact the HCSIS helpdesk at **1-866-444-1264**.
- Need the "Search for CHC Participants" checkbox in order to search for CHC Participants.
  - Contact the HCSIS helpdesk for assistance to add this checkbox if needed.
- Need to use the Participant's Medicaid ID (MCI) or Social Security Number (SSN) when entering the Identifier Type to search a Participant. This can be obtained from the Participant.
- If any questions, contact the CI mailbox at KFCHCCriticalincident@keystonefirstchc.com.

Critical Incident Reporting (continued)

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

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

The following are critical incidents that must be reported:

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

Critical Incident Reporting (continued)

- 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.

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

Cultural Competency (continued)

DHS defines Cultural Competency as:

The ability of individuals to understand the social, linguistic, moral, intellectual and behavioral characteristics of a community or population, and translate this understanding systematically to enhance the effectiveness of healthcare delivery to diverse populations.

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

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

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

Cultural Competency Resources and Training

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

Provider Services

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 make sure Network Providers receive the highest level of service available.

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

Provider Network Management

Provider Network Management responsibilities include:

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

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

Secure Provider Portal

NaviNet is an easy-to-use, free, web-based solution that links Providers to Keystone First CHC.

NaviNet delivers:

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

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

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

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

Provider Obligation to Notify Plan of Changes

As a reminder, Providers are contractually bound to report changes that affect referrals, such as the relocation of an office site and to ensure that all service locations are registered and enrolled with DHS and have an active MMIS/PPID for each location.

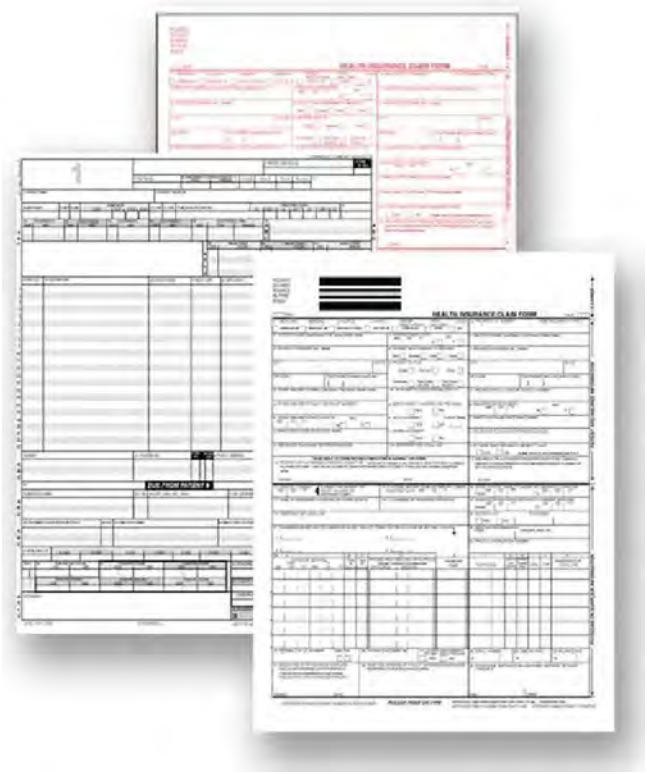
The LTSS Provider Change Form can be found in the Provider Center on our website at www.keystonefirstchc.com → For Providers → Provider manual and forms.

Providers are responsible to notify their Account Executive immediately of the following changes:

- Change of ownership
- Change to the name of the entity (including DBA)
- Change to the Tax ID Number or Employer Identification Number
- Change to the Group Medicaid ID Number (PPID/MPI)
- Change in the status of the business filing with the Pennsylvania Department of State
- Change in service location address (change must first be approved as PA DHS active type 59 with CHC)
- Demographic changes (e.g., remittance address, phone numbers, point of contact, etc.)

**** Unreported changes may result in payment delays.****

Claims and Billing



Claims Filing Timeframes

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

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

Verifying Eligibility

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

1. PROMISe™

- Go to https://promise.dhs.pa.gov/portal/provider/Home/tabid/135/Default.aspx
- HIPAA compliant PROMISe software (Provider Electronic Solutions Software) is available free-of-charge. Download from the OMAP PROMISe website at https://promise.dhs.pa.gov/ePROM/_ProviderSoftware/softwareDownloadForm.asp?m=1

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

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

3. NaviNet: www.navinet.net

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

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

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

Encounter Data Reporting

- Encounters are defined as “an interaction between an individual and the health care system”.
- Encounters, regardless of compensation method must result in the creation and submission of an encounter record to the Plan via CMS-1500 or 837 format.
- Encounter submission is critical for:
  - Data that the Plan reports to DHS.
  - Providing reimbursement for services covered above capitation (if applicable).
  - Gathering statistical information regarding medical services provided to Participants.
  - Assisting us in identifying the severity of illnesses of our Participants.

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

Claim Resubmissions

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Electronic submission

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

- Resubmit within 365 days of the date of service.

Mail submission

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

Rejected claims definition:

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

Denied claims definition:

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

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

Electronic Visit Verification (EVV)

As required by the Pennsylvania Department of Human Services, Office of Long-Term Living (PA-DHS/OLTL), and 21st Century Cures Act, all HCBS Providers who provide and bill for personal care services (PCS), home health care services (HHCS), and respite services are required to use the EVV System.

- EVV is an electronic system that verifies when Provider visits occur and documents the precise time services begin and end.
- Matching EVV data for the corresponding billed dates of service is required for claim lines billed with PCS, HHCS, and respite service codes for dates of service.
- All claims billed without matching EVV must be verified by the Provider prior to billing. Documentation, including a hard copy/paper timesheet, of the verification must be provided upon request.
- Timesheets must include the following data elements:
  - Agency name, TIN, and Provider ID
  - Direct Care Worker's Name and last 4 digits of SSN
  - Participant Name and Medicaid ID #
  - Date of Service, Service Location, Start and End Time, Total Hours Worked
  - Services Provided based on Plan of Care
  - Participant's, Provider's, and Direct Care Worker's signature and date

EVV, continued

- EVV compliance is monitored by the Plans and PA-DHS/OLTL. PA-DHS/OLTL has communicated that Providers are expected to achieve at least **85%** of EVV records for verified visits without manual edits.
- Providers should monitor their EVV compliance on a weekly basis and educate staff on EVV requirements.
- Providers' manual edits percentage are monitored monthly. Providers not meeting minimal monthly percentages will be placed on a Corrective Action Plan (CAP). Failure to achieve and maintain compliance with EVV may result in termination from the network.

For up-to-date EVV information on our website, go to
www.keystonefirstchc.com → For Providers → Training

https://www.pa.gov/content/dam/copapwp-pagov/en/dhs/documents/docs/publications/documents/forms-and-pubs-omap/MAB2022081001.pdf

Coordination of Benefits (COB)

- **Medicaid** is always the **payer of last resort**
- May be submitted in both paper and electronic formats
- Submit claims involving COB within 60 days of receipt of primary carrier's remittance with the following:
  - Claim form
  - Primary carrier's EOB or denial notification (dates and dollars must match)
- Primary Insurer
  - Must follow requirements for both plans

Third Party Liability (TPL)

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Sources of TPL

- State file feeds
- Vendor file feeds

Manual entry (TPL associates)

- Participant identified
- Provider identified
- Internal department identified

What to do if a TPL denial is received

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

Claims Disputes

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

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

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

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

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

Electronic Billing

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Electronic Data Interchange (EDI)

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

Claim Submission

Electronic claim submission options:

- Electronic Data Interchange (EDI) payer ID number is
  - Keystone First CHC: **42344**
- To be set up to bill electronically with:
  - Change Healthcare: Please visit our website for the latest information related to billing through Change Healthcare.
  - Availity: https://www.availity.com/Essentials-Portal-Registration
  - PCH Global: https://pchhealth.global
  - HHA Exchange: https://www.hhaexchange.com/info-hub/pennsylvania-community-healthchoices

You can also visit our websites to view our claims filing guides and information on submitting claims by mail: www.keystonefirstchc.com → For Providers → Claims and billing.

Electronic Funds Transfer (EFT)

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

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

- For complete information, including enrollment guide, quick reference guide and FAQ, go to our website: www.keystonefirstchc.com → For Providers → Claims and billing.

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

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

Electronic Remittance Advice (ERA)

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

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

Fraud, Waste, Abuse, and Mandatory Screening Information

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

Reminders:

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

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

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

Reporting and Preventing Fraud, Waste, and Abuse

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

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

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

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

Resources

- **State Community HealthChoices web page**: https://www.pa.gov/agencies/dhs/resources/medicaid/chc.html
- **DHS ListServ** - DHS email updates with important CHC information:
  - https://www.dhs.pa.gov/about/Pages/Listservs.aspx
  - You will receive an email message with a confirmation code will be sent to the address you specify.
  - Simply wait for this message to arrive, then follow the instructions to confirm your subscription.
- **Pennsylvania Department of Aging**: https://www.aging.pa.gov/Pages/default.aspx
- **Suspect elder abuse or abuse of an adult with a disability?**

  https://www.dhs.pa.gov/about/Fraud-And-Abuse/Pages/Adult-Protective-Services.aspx
- **PA Medicaid Fraud Control Act:** *The Pennsylvania Fraud and Abuse Controls, 62 P.S. §§ 1407, 1408*
- **Keystone First Community HealthChoices website**: https://www.keystonefirstchc.com

Resources (continued)

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

Important Contact Information

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Email:
CHCProviders@keystonefirstchc.com

Provider Services phone line:

1-800-521-6007

Our website:
www.keystonefirstchc.com

Thank you!

Please attest that you have completed this annual training requirement at https://www.surveymonkey.com/r/G57BN96

We need and appreciate your feedback!