

Community HealthChoices

O V E R V I E W



pennsylvania
DEPARTMENT OF HUMAN SERVICES

WHAT IS COMMUNITY HEALTHCHOICES (CHC)?

A Medicaid managed care program that will include physical health benefits and long-term services and supports (LTSS). The program is referenced to nationally as a managed long-term services and supports program (MLTSS).

WHO IS PART OF CHC?

- Individuals who are 21 years of age or older and dually eligible for Medicare and Medicaid.
 - ✓ Individuals with intellectual or developmental disabilities who are eligible for services through the Office of Developmental Program will not be enrolled in CHC.
- Individuals who are 21 years of age or older and eligible for Medicaid (LTSS) because they need the level of care provided by a nursing facility.
 - ✓ This care may be provided in the home, community, or nursing facility.
 - ✓ Individuals currently enrolled in the LIFE Program will not be enrolled in CHC unless they expressly select to transition from LIFE to a CHC managed care organization (MCO).

WHO IS NOT PART OF CHC?

- People receiving long-term services & supports in the OBRA waiver & are not nursing facility clinically eligible (NFCE)
- A person with an intellectual or developmental disability receiving services beyond supports coordination through the Department of Human Services' Office of Developmental Programs
- A resident in a state-operated nursing facility, including the state veterans' homes

CHC STATEWIDE POPULATION

12%

49,759

Duals in Waivers

64%

270,114

Healthy Duals

16%

IN WAIVERS

20%

IN NURSING FACILITIES

420,618

CHC POPULATION

94%

DUAL-ELIGIBLE

18%

77,610

Duals in Nursing
Facilities

4%

15,821

Non-duals in
Waivers

2%

7,314

Non-duals in
Nursing Facilities

CHC SOUTHEAST POPULATION

23%

28,887

Duals in Waivers

56%

72,882

Healthy Duals

33%

IN WAIVERS

11%

IN NURSING FACILITIES

127,726

CHC POPULATION

89%

DUAL-ELIGIBLE

10%

12,456

Duals in Nursing
Facilities

10%

12,136

Non-duals in
Waivers

1%

1,365

Non-duals in
Nursing Facilities

CHC SOUTHEAST POPULATION

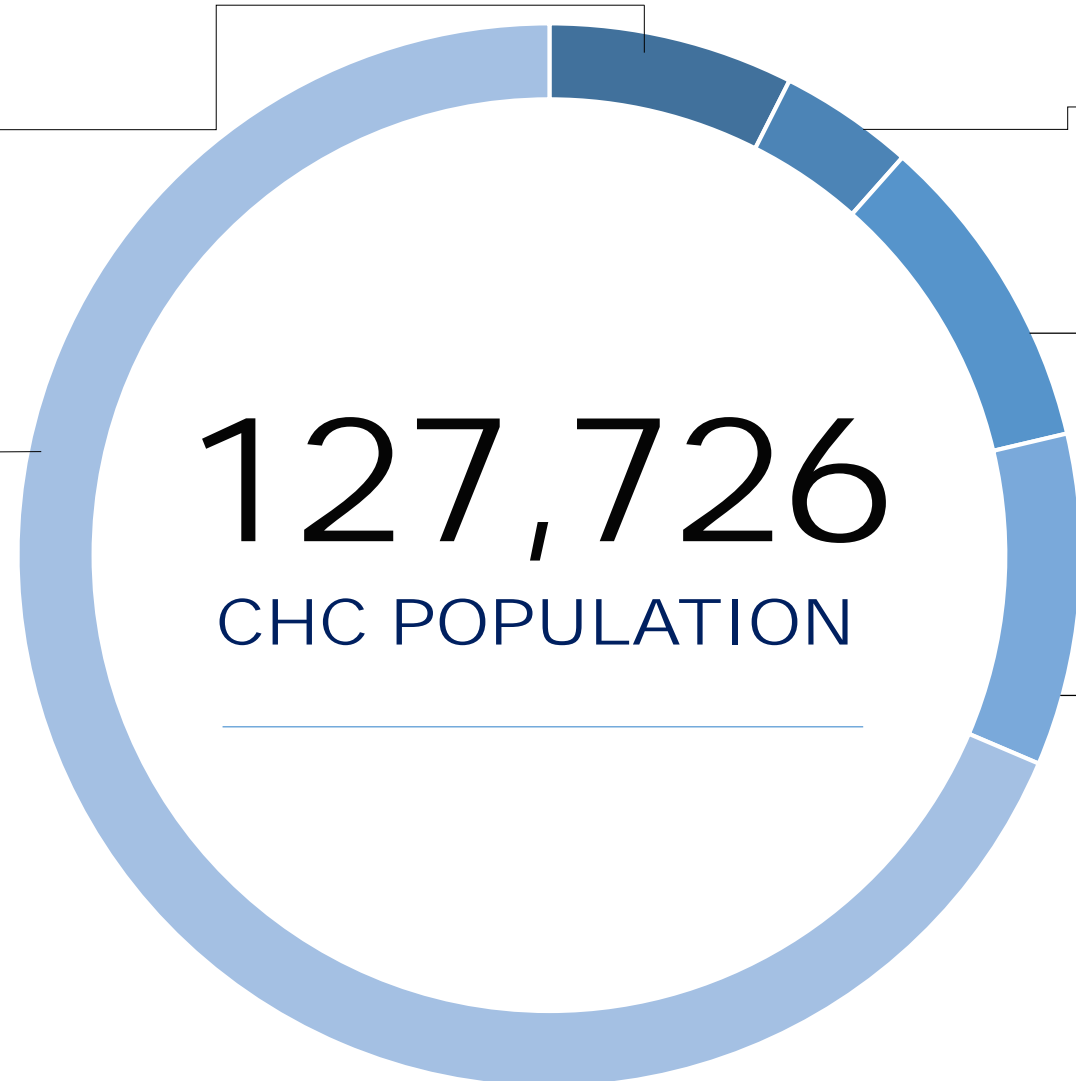
7%
9,479
Bucks County

4%
5,212
Chester County

69%
87,231
Philadelphia
County

10%
12,429
Delaware County

10%
12,826
Montgomery
County



127,726
CHC POPULATION

HOW DOES CHC WORK?

Participants

- Choose their MCO
- Should consider the provider network and additional services offered by the MCOs



DHS

- Pays a per-member, per-month rate (also called a capitated rate) to MCOs
- Holds the MCOs accountable for quality outcomes, efficiency, and effectiveness



MCO

- Coordinates and manages physical health and LTSS for participants
- Works with Medicare and behavioral health MCOs to ensure coordinated care
- Develops a robust network of providers

WHAT ARE THE GOALS OF CHC?

GOAL 1

Enhance opportunities for community-based living.

GOAL 2

Strengthen coordination of LTSS and other types of health care, including all Medicare and Medicaid services for dual eligibles.

GOAL 3

Enhance quality and accountability.

GOAL 4

Advance program innovation.

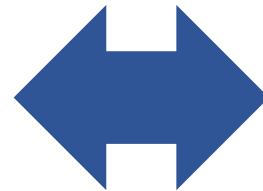
GOAL 5

Increase efficiency and effectiveness.

COMPARISON OF FFS VS. MANAGED CARE

FEE-FOR-SERVICE

- Providers enroll as Medicaid providers
- Providers contract with the Commonwealth
- Providers bill PROMISE



MANAGED CARE

- Providers enroll as Medicaid providers
- Providers contract with MCOs
- Providers bill MCOs

COVERED SERVICES

FOR ALL PARTICIPANTS:

Physical health services

All participants will receive the Adult Benefit Package, which is the same package they receive today.

This includes services such as:

- Primary care physician
- Specialist services
- Please note: Medicare coverage will not change.

COVERED SERVICES

FOR ALL PARTICIPANTS:

Behavioral health services

All participants will receive behavioral health services through the Behavioral Health HealthChoices MCOs.

Services available to participants include but are not limited to:

- Inpatient Psychiatric Hospital
- Inpatient Drug and Alcohol Detox and Rehabilitation
- Psychiatric Partial Hospitalization
- Outpatient Psychiatric Clinic
- Drug and Alcohol Outpatient Clinic

This is new for Aging Waiver participants and nursing facility residents, who receive behavioral health services through fee-for-service.

COVERED SERVICES

TRANSPORTATION SERVICES:

- All CHC participants have access to emergency and non-emergency medical transportation.
- Participants will continue to use the Medical Assistance Transportation Program (MATP) for non-emergency medical transportation to and from medical appointments.
 - Participants residing in nursing facilities are the exception.
 - Nursing facilities will continue to coordinate transportation for their residents.
- Nursing facility clinically eligible (NFCE) participants also have access to non-medical transportation. Non-medical transportation can include:
 - Transportation to community activities, religious services, employment and volunteering, and other activities or LTSS services as specified in the Participant's Person-Centered Service Plan (PCSP).
 - This service is offered in addition to medical transportation services and shall not replace them.
 - These services may include the purchase of tickets or tokens to secure transportation for a participant.

COVERED SERVICES

FOR PARTICIPANTS WHO QUALIFY FOR LTSS:

- Home and community-based long-term services and supports including:
 - ✓ Personal assistance services
 - ✓ Home adaptations
 - ✓ Pest eradication
- Long-term services and supports in a nursing facility
- Participant-directed services will continue as they exist today.

CONTINUITY OF CARE

- MCOs are required to contract with all willing and qualified existing LTSS Medicaid providers for 180 days after CHC implementation.
- Participants may keep their existing LTSS providers for the 180-day continuity of care period after CHC implementation.
- For nursing facility residents, participants will be able to stay in their nursing facility as long as they need this level of care, unless they choose to move.
- The commonwealth will conduct ongoing monitoring to ensure the MCOs maintain provider networks that enable participants choice of provider for needed services.

IDENTIFYING NEEDS

SCREENING, COMPREHENSIVE NEEDS ASSESSMENT AND REASSESSMENT

- CHC-MCOs must:
 - screen each new participant who are healthy duals within 90 days of the start date
 - conduct a comprehensive needs assessment of every participant who is determined NFCE
 - conduct a comprehensive assessment when the participant makes a request, self-identifies as needing LTSS, or if either the CHC-MCO or the Internet Enrollment Broker (IEB) identifies that the participant has unmet needs, service gaps or a need for service coordination
 - conduct a reassessment at least every 12 months unless a trigger event occurs

PLANNING

CARE MANAGEMENT PLANS

A care management plan is used to identify and address how the participant's physical, cognitive, and behavioral health care needs will be managed.

PERSON-CENTERED SERVICE PLANS (PCSP)

All LTSS participants will have a PCSP. The PCSP includes both the care management plan and the LTSS services plan.

PCSPs are developed through the person-centered planning team process, which includes the participant, service coordinator, participant's supports, and participant's providers.

COORDINATION WITH MEDICARE

Promoting improved coordination between Medicare and Medicaid is a key goal of CHC. Better coordination between these two payers can improve participant experience and outcomes.

- Dually eligible participants will continue to have all of the Medicare options they have today, including Original Medicare and Medicare Advantage managed care plans. The implementation of CHC will not change the services that are covered by Medicare.
- All CHC-MCOs are required to offer a companion Dual Eligible Special Needs Plans, also known as D-SNPs to its dually eligible participants. D-SNPs are a type of Medicare Advantage plan that coordinates Medicare and Medicaid services.
- Medicare will continue to be the primary payor for any service covered by Medicare. Providers will continue to bill Medicare for eligible services prior to billing Medicaid. All Medicaid bills for participants will be submitted to the participant's CHC-MCO, including bills that are submitted after Medicare has denied or paid part of a claim.
- Participants must have access to Medicare services from the Medicare provider of his or her choice. The CHC-MCO is responsible to pay any Medicare co-insurance and deductible amount, whether or not the Medicare provider is included in the CHC-MCO's provider network.

SERVICE COORDINATION OBJECTIVES

- Every participant receiving LTSS will choose a service coordinator.
- The service coordinator will coordinate Medicare, LTSS, physical health services, and behavioral health services.
- They will also assist in accessing, locating and coordinating needed covered services and non-covered services such as social, housing, educational and other services and supports.
- The service coordinator will also facilitate the person-centered planning team.
- Each participant will have a person-centered planning team that includes their doctors, service providers, and natural supports.



PROVIDER PAYMENTS

PROVIDER PAYMENTS

How Are Provider Rates Determine?

- CHC-MCOs are paid a set amount per member per month, which is called a capitation rate.
- The capitation rates were developed using historical fee-for-service data and adjusted for considerations such as additional benefits, projecting the data forward, and adjustment for managed care principals such as lowered inpatient hospitalization through improve coordination.
- 2019 capitation rates have been developed with the understanding that CHC enrollees currently using LTSS have a continuity of care period as defined in the CHC agreement.
- After the continuity of care period, CHC-MCOs will negotiate reimbursement rates with providers.
 - The CHC-MCOs may negotiate with providers to perform specialized services such as eye drops, wound care, and bowel care management.
 - The CHC-MCO may have regional rate variations.
 - DHS will not be involved in the negotiation.

PROVIDER PAYMENTS

How Are Provider Rates Determine?

- The capitation rates provide sufficient funds that allow the CHC-MCOs to negotiate rates, on average, that are equivalent to the Fee-for-Service rate.
- The MCOs and DHS have agreed upon tools to address the risk of high cost participants.

PROVIDER PAYMENTS

HOW ARE PROVIDERS PAID FOR SERVICES?

- Provider must bill the appropriate CHC-MCO to receive reimbursement for services after January 1, 2019
 - Services prior to January 1, 2019 must be billed to DHS via PROMISe for reimbursement.
- Each CHC-MCO may have their own claim system.
- CHC-MCOs are required to train providers on claims submission, any electronic visit verification system, other software systems such as their service coordination system, as well as many other aspects of CHC.

PROVIDER PAYMENTS

HOW ARE PROVIDERS PAID FOR SERVICES?

- Providers will have the opportunity to participate in claims testing through the readiness review process.
- CHC-MCOs must adjudicate 90% of clean claims in 30 days and 100% in 45 days from date of receipt.
 - CHC-MCOs will determine payment cycles.
 - DHS will use monthly claim processing file to determine compliance with claims processing standards.
 - If DHS determines that a CHC-MCO has not complied with the claims processing timeliness standards, DHS may separately impose sanctions on the CHC-MCO.



WHERE
IS IT NOW?

SOUTHWEST IMPLEMENTATION

- Successfully implemented the southwest on January 1, 2018
- Approximately 79,000 Participants were transitioned to the CHC program
- Lessons Learned (so far)
 - Earlier stakeholder engagement opportunities
 - Enhanced communication materials and training regarding Medicare vs. CHC
 - More education and communication on continuity-of-care
 - MCO Provider Training and outreach to occur earlier and more often
 - Earlier OBRA reassessments
 - Earlier data clean-up in HCSIS and SAMS
 - Earlier pre-transition notices
- Transportation issues

SOUTHEAST IMPLEMENTATION

- Comprehensive participant communication
- Robust readiness review
- Provider communication and training
- Pre-transition and plan selection for southeast participants
- Incorporation of southwest implementation and launch lessons learned

PRIORITIES THROUGH IMPLEMENTATION

ESSENTIAL PRIORITIES

- No interruption in participant services
- No interruption in provider payment

HOW WILL WE ENSURE NO INTERRUPTIONS?

- The Department of Human Services (Department) is engaged with the MCOs in a rigorous readiness review process that looks at provider network adequacy and IT systems.
- The Department of Health must also review and approve the MCOs to ensure they have adequate networks.

PRIORITIES THROUGH IMPLEMENTATION

READINESS REVIEW

- Information systems
- Network adequacy
- Member materials and services



STAKEHOLDER COMMUNICATION

- Participants and caregivers
- Providers
- Public



DHS PREPAREDNESS

- General Information
- Training
- Coordination between offices
- Launch indicators

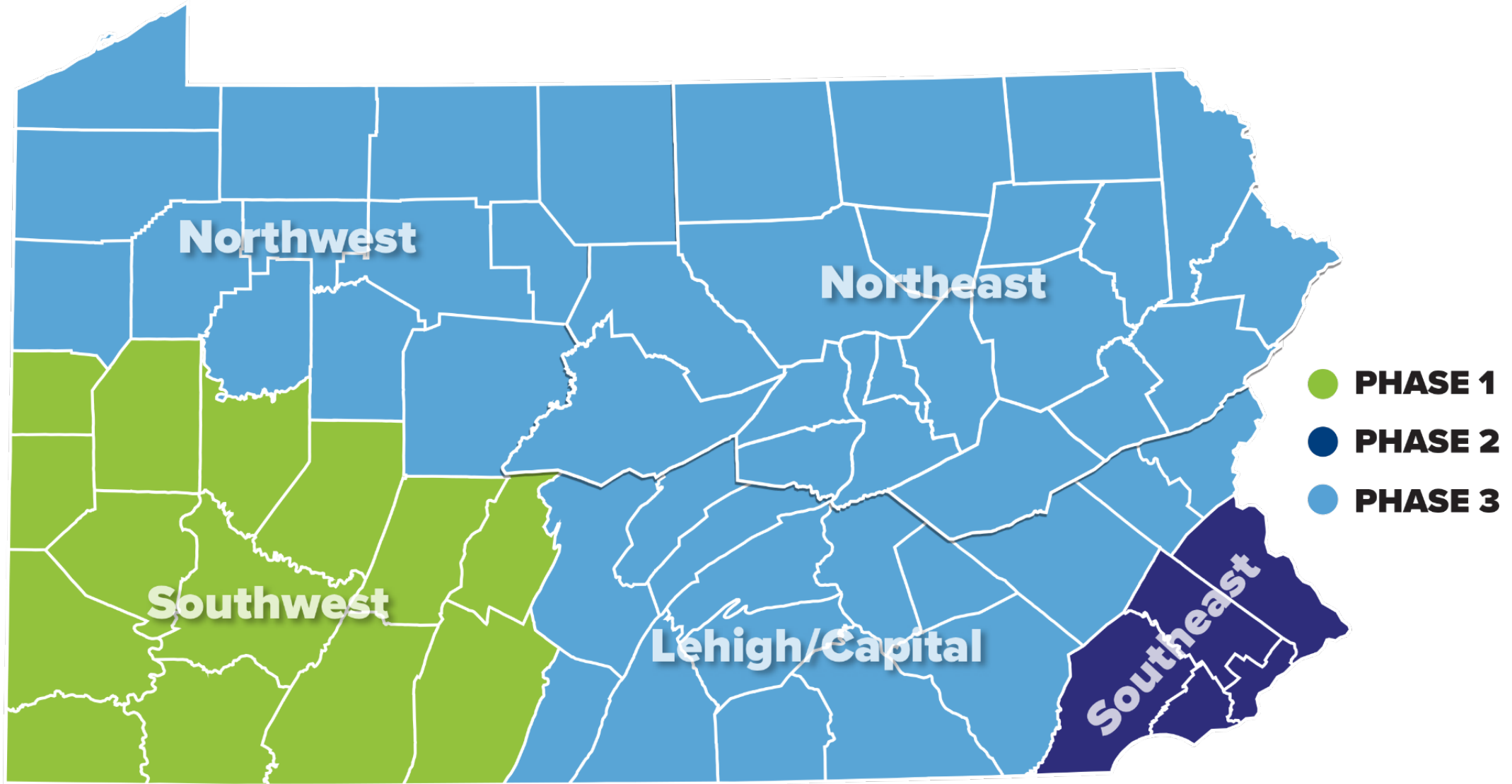
NETWORK ADEQUACY

PHYSICAL HEALTH

- CHC-MCOs will be required to meet the existing HealthChoices network adequacy requirements.

LTSS

- National MLTSS network adequacy standards aren't available.
- The Department worked with consumers to help develop standards.
- The Department gathered information to establish a baseline of the number of full time equivalents (FTEs) that are potentially needed to continue to provide services and meet the needs of the participants.
- The CHC-MCOs are asking providers for this information during a provider's initial enrollment with an MCO and on an ongoing basis.
- DHS will re-evaluate network adequacy at the end of the 180-day continuity of care period to ensure consumers have access to LTSS.
- The commonwealth will conduct ongoing monitoring to ensure the MCOs maintain provider networks that enable participants choice of provider for needed services.



MANAGED CARE ORGANIZATIONS

- The selected offerors were announced on August 30, 2016.



➤ www.Keystonefirstchc.com



➤ www.PAHealthWellness.com

UPMC Community HealthChoices

➤ www.upmchealthplan.com/chc



COMMUNICATIONS



www.HealthChoices.pa.gov



What's New?
Publications

Community HealthChoices

[READ](#) CHC Question and Answer Document [VIEW](#) CHC Publications

[SUBSCRIBE](#) for the latest CHC news

- Related Topics**
- [Presentations](#)
 - [Publications](#)
 - [Supporting Documents](#)
 - [Third Thursday Webinars](#)

Community HealthChoices (CHC) is Pennsylvania's mandatory managed care program for individuals who are eligible for both Medical Assistance and Medicare (dual eligibles), older adults, and individuals with physical disabilities — serving more people in communities while giving them the opportunity to work, spend more time with their families, and experience an overall better quality of life. When implemented, CHC will improve services for hundreds of thousands of Pennsylvanians.

TRAINING

These trainings have been created to help providers answer questions about CHC.

[CHC Overview Training](#) (Approx. 30 minutes)

Direct Service Providers

[Direct Service Provider Online Course](#) (Approx. 45 minutes)

Service Coordinators

- For the general public - [Service Coordination Online Course](#) (Approx. 45 minutes)

- For service coordinators only, visit the following [website](#) for instructions on how to complete the training which includes a test to verify competency.

Nursing Facilities

- For the general public - [Nursing Facility Training](#) (Approx. 40 minutes)

- For nursing facilities only, visit the following [website](#) for instructions on how to complete the training.

- Nursing Facility Eligibility and Enrollment Process [webinar](#) | [powerpoint](#)

PROVIDER DOCUMENTS

General

[CHC Acronym Glossary Guide](#)

[What is CHC?](#)

[Who is served by CHC?](#)

[Community HealthChoices vs. HealthChoices](#)

[Informational flyer](#)

[Timeline for Implementation](#)

[Provider Eligibility](#)

Benefits/Service Coordination

[Service Coordination](#)

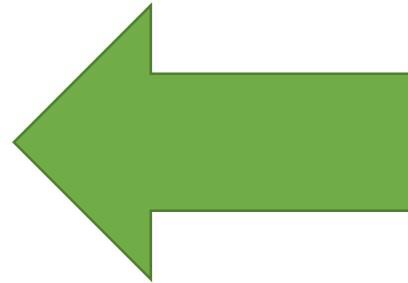
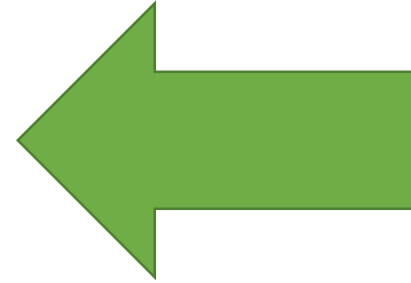
[Continuity of Care](#)

[Long-Term Services Guide](#)

[Adult Benefits Package](#)

[Behavioral Health Provider Update](#)

[Coordination with Medicare](#)



PROVIDERS

- Bi-weekly email blasts on specific topics
 - ✓ Examples: Billing, Service Coordination, Medicare, HealthChoices vs. CHC, Continuity of Care
- Provider narrated training segments
- Provider events in local areas to meet with MCOs and gain information about CHC



Community HealthChoices

****RSVP**
to Southeast provider
meetings

READ
CHC participant
documents



VIEW
publications

SUBSCRIBE
for the latest CHC
news

- #### Related Topics
- [Community HealthChoices Publications](#)
 - [Supporting Documents](#)
 - [Third Thursday Webinars](#)
 - [Communications to Participants](#)



PARTICIPANTS

AWARENESS FLYER

- Mailed five months prior to implementation. Southeast: July 2018

AGING WELL EVENTS

- Participants will receive invitations for events in their area. Southeast: August 2018

PRE-TRANSITION NOTICES AND ENROLLMENT PACKET

- Mailed four months prior to implementation. Southeast: August 2018

SERVICE COORDINATORS

- Will reach out to their participants to inform them about CHC. Southeast: September 2018

NURSING FACILITIES

- Discussions about CHC will occur with their residents. Southeast: September 2018

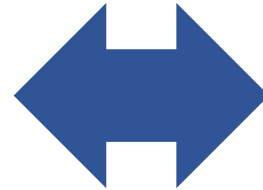


PARTICIPANTS

COMPARISON OF FFS VS. MANAGED CARE

FEE-FOR-SERVICE

- Provide necessary documentation to the Department
- Contact a service coordination entity to coordinate services
- Receive service from a provider



MANAGED CARE

- Provide necessary documentation to the Department
- Enroll in a MCO and work with the MCO to coordinate and receive necessary services
- Receive services from a provider

WHAT IS NECESSARY?

- Select an MCO by the date indicated by the Department.
 - ✓ Get information on the different plans by going to www.enrollCHC.com.
- Educate yourself.
 - ✓ Participate in CHC Third Thursday webinars to learn more about CHC.
 - ✓ Participate in stakeholder engagements.
 - ✓ Read CHC-related information sent to you by the Department.
 - ✓ Participate in upcoming educational sessions hosted by Aging Well.



PROVIDERS

WHAT IS NECESSARY?

- Contact MCOs to discuss contracting.
 - ✓ All providers will need to contract with the MCOs to provide services through the continuity of care period.
- Educate yourself.
 - ✓ Participate in CHC Third Thursday webinars to learn more about CHC.
 - ✓ Participate in stakeholder engagements.
 - ✓ Read and share within your organization any CHC-related information sent to you by the Department.
 - ✓ Participate in upcoming educational sessions hosted by the Department.

RESOURCE INFORMATION

CHC LISTSERV // STAY INFORMED: <http://listserv.dpw.state.pa.us/oltl-community-healthchoices.html>

COMMUNITY HEALTHCHOICES WEBSITE: www.healthchoices.pa.gov

MLTSS SUBMAAC WEBSITE:

www.dhs.pa.gov/communitypartners/informationforadvocatesandstakeholders/mltss/

EMAIL COMMENTS TO: RA-PWCHC@pa.gov

OLTL PROVIDER LINE: 1-800-932-0939

OLTL PARTICIPANT LINE: 1-800-757-5042

INDEPENDENT ENROLLMENT BROKER: 1-844-824-3655 or (TTY 1-833-254-0690)

or visit www.enrollchc.com

Established Statewide Quality Strategy Plan

Stakeholder Themes:

- Ensure that **participants AND providers** have mechanics in place to include:
 - An independent system (Beneficiary Support System, as defined under the managed care final rule).
 - Participant and provider hotline numbers continue at the state level.
 - Continuous communication
 - Person-Centered Planning Process
- Continue to **promote stakeholder engagement** among:
 - DHS
 - MCO
 - Providers
 - Participants
 - Advocates
- Continue to have **program transparency**:
 - Report on performance measures and outcomes to stakeholders:
 - Consumer and provider satisfaction surveys
 - Critical incidents / reports of abuse
 - Incorporate pay for performance initiatives
 - Monitoring of program
- Ensure **participant choice**
 - Community living
 - Nursing home
 - Service providers
- **Diversity inclusion**
 - Ethnicity
 - LGBT population
 - Various translations available



QUALITY

QUALITY

WHAT MEASURES WILL BE USED TO MEASURE QUALITY?

- Comprehensive list of *proposed* measures

National

- Healthcare Effectiveness Data & Information Set (HEDIS)(Adults)
- CMS Adult Core
- CMS Nursing Facility
- Consumer Assessment of Healthcare Providers & Systems (CAHPS)
- CMS Medicare measures for Dual Eligible Special Needs Plans

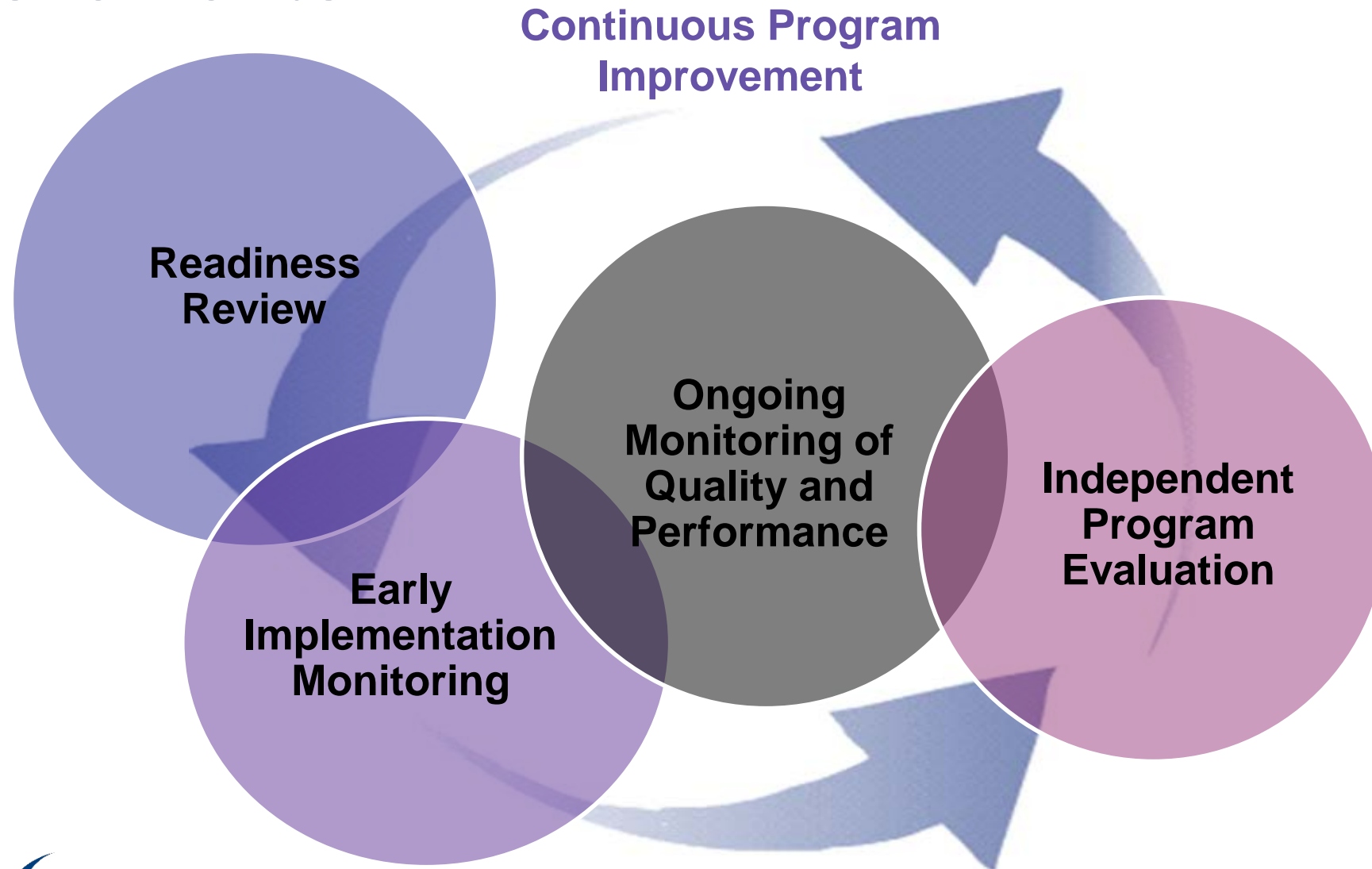
State

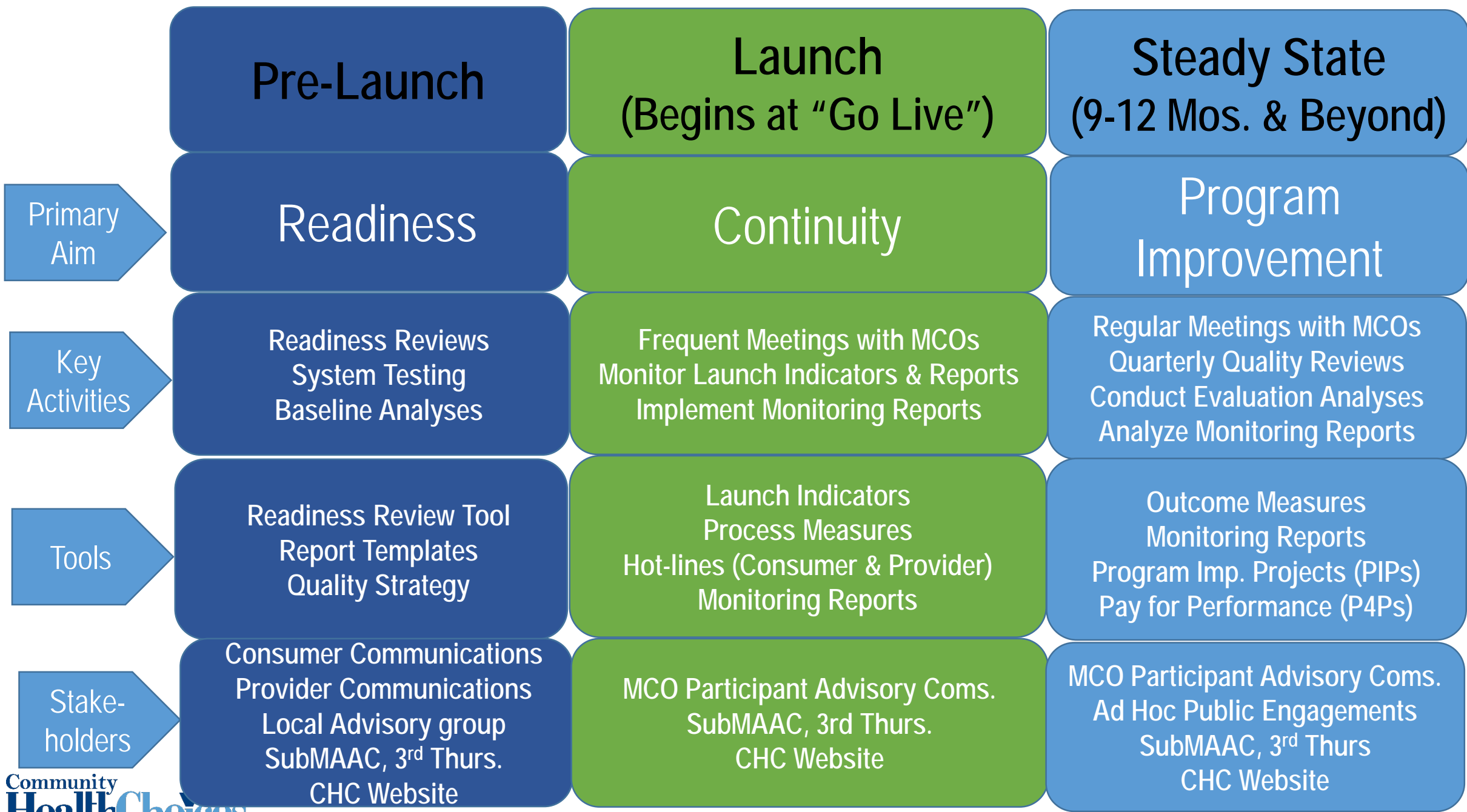
- LTSS Community Based Services
- Service Coordination and Care Coordination
- Grievances, Appeals & Critical Incidents
- Rebalancing
- CHC HCBS Waiver Assurances

Launch Indicators

- Key data points provided frequently during launch
- Focus on:
 - Continuity of Services
 - LTSS Provider Participation

Key Components of Quality Assurances & Improvements







QUESTIONS