Community HealthChoices

COORDINATION WITH MEDICARE

COMMUNITY HEALTHCHOICES (CHC) is Pennsylvania's mandatory managed care program for individuals who are dually eligible for both Medicaid and Medicare, 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 fully implemented, CHC will improve services for hundreds of thousands of Pennsylvanians.

APPROXIMATELY 94 PERCENT OF CHC PARTICIPANTS ARE DUAL-ELIGIBLES — meaning they receive health care coverage from both Medicare and Medicaid. 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.

Both Medicare and Medicaid cover physical health services such as doctors' visits, hospital stays, lab tests, and pharmaceuticals. Medicaid is the payer of last resort. Once Medicare — and any other health insurance coverage the participant has — have paid or denied the claim, Medicaid should be billed for the remainder of the claim. This does not change under CHC.

- For additional CHC fact sheets, visit **www.healthchoices.pa.gov/providers/about/community.**
- **Questions?** Visit **www.healthchoices.pa.gov** or call our CHC Provider Hotline at **800-932-0939.**

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CHC'S IMPACT ON MEDICARE SERVICES

WHAT DOESN'T CHANGE:

- Dually eligible participants will continue to have all of the Medicare options they have today, including Original Medicare and Medicare Advantage managed care plans. Their Medicare will not change unless they decide to change it.
- 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.
- This will not change the services that are covered by Medicare.
- Providers cannot balance-bill dually eligible participants when either Medicare or Medicaid does not cover the entire amount billed for a service delivered.
- Participants must have access to Medicare services from the Medicare provider of his or her choice. The CHC managed care organization (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 and whether or not the Medicare provider has complied with the prior authorization requirements of the CHC-MCO.

WHAT'S DIFFERENT:

- Each CHC-MCO is required to offer a companion Medicare managed care plan to its dually eligible participants. These plans are called Dual-Eligible Special Needs Plans (D-SNPs). Like today, enrolling in a D-SNP is voluntary for the participant. Under CHC, participants will have an opportunity for a more coordinated approach to their care and may receive additional benefits by enrolling in their CHC-MCO's companion D-SNP. For providers, the coordinated option will help streamline the Medicare and Medicaid billing processes, since participants who choose it will get all their Medicare and Medicaid services through a single health plan. This will also cut down on confusion surrounding the responsibilities of payment and improve health care coordination for participants.
- Once CHC is implemented, 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. Medicaid providers will no longer send these bills directly to the Department of Human Services.
- The CHC-MCO may not require prior authorization for services covered by Medicare. However, if service is denied by Medicare or there is a limit on the service of Medicare, the CHC-MCO may require prior authorization for the equivalent Medicaid service, as long as the CHC-MCO has a prior authorization policy that was approved by the state. Service coordinators will work with participants to coordinate prior authorization of services when needed.

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