Community HealthChoices

GENERAL ASSEMBLY
O V E R V I E W

October 31, 2017
3pm

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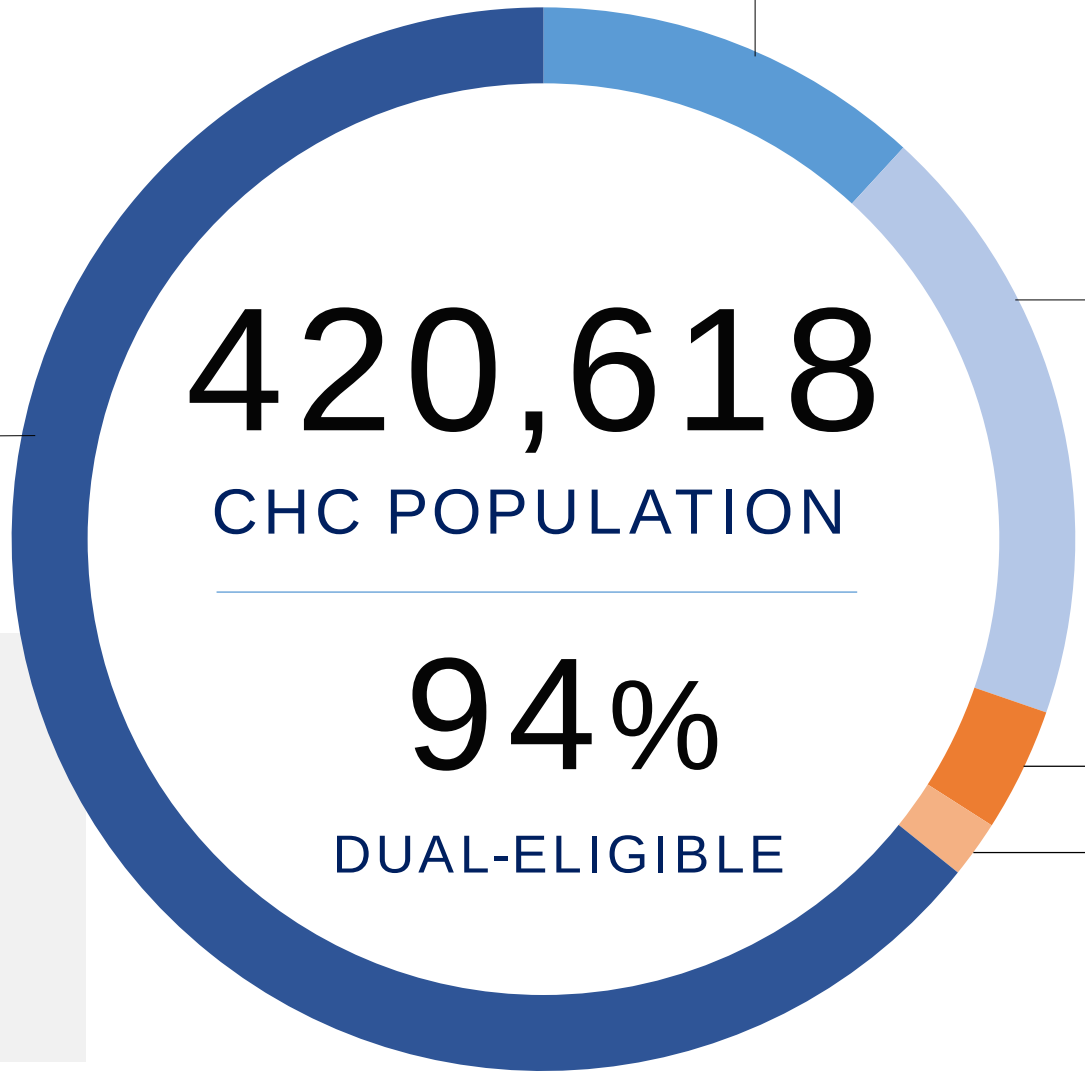
pennsylvania
DEPARTMENT OF HUMAN SERVICES

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).



12%
49,759
Duals in Waivers

64%
270,114
Healthy Duals

18%
77,610
Duals in Nursing Facilities

4%
15,821
Non-duals in Waivers

2%
7,314
Non-duals in Nursing Facilities

16%
IN WAIVERS

20%
IN NURSING FACILITIES

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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 through the Department of Human Services' Office of Developmental Programs
- A resident in a state-operated nursing facility, including the state veterans' homes

HOW DOES CHC WORK?

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

Participants

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

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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.

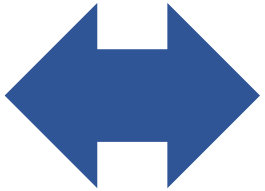
GOAL 5

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
- Participants use Medicaid-enrolled providers



MANAGED CARE

- Providers enroll as Medicaid providers
- Providers contract with MCOs
- Providers bill MCOs
- Participants use providers that are part of the MCO network

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WHY MAKE THE CHANGE?

Managed care organizations will reduce barriers & challenges by:

- Making sure all eligible services are easily accessible and in one place
- Helping people plan
- Simplifying the process of managing healthcare, homecare & supports

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.

Behavioral health services

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

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

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 Medicaid providers for 180 days after CHC implementation.
- Participants may keep their existing 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 independent 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 PSCP 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.

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.

SERVICE COORDINATION DURING AND AFTER CONTINUITY OF CARE

After the 180 day transition period the MCO has the option to:

- Contract with & use existing service coordination entities
- Hire staff to perform service coordination
- Use a combination of existing service coordination entities & internal staff

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WHERE IS IT NOW?

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 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

Readiness Review – Network Adequacy

PHYSICAL HEALTH

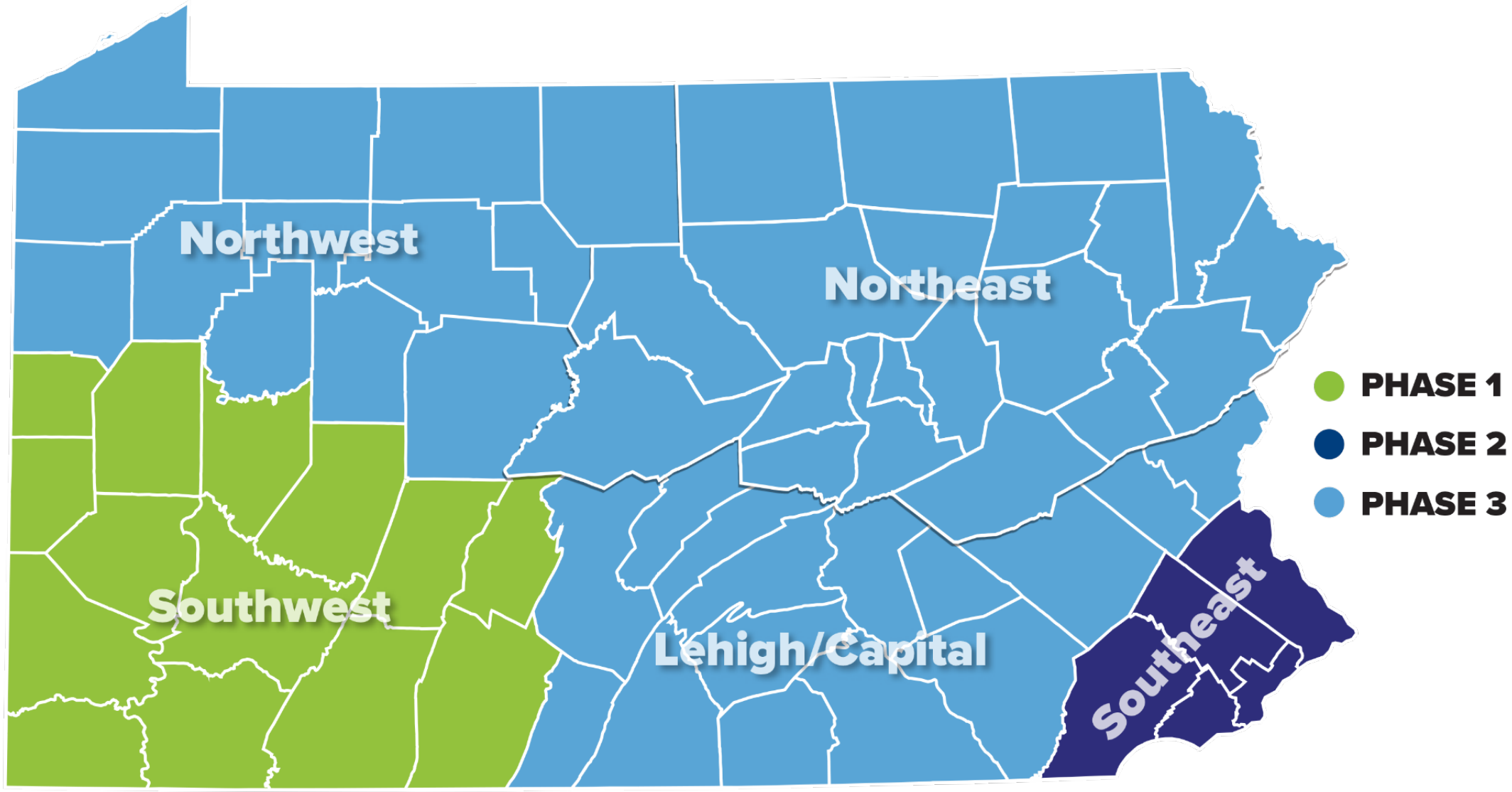
- CHC-MCOs are required to meet the existing HealthChoices network adequacy requirements.
  - Department of Health is working with the CHC-MCOs to address potential gap areas

LTSS

- National MLTSS network adequacy standards aren't available and current LTSS participants and advocates helped to inform the standards used.
- Departments of Health and Human Services are working with CHC-MCOs to finalize LTSS networks

ONGOING

- 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.



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MANAGED CARE ORGANIZATIONS

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

AmeriHealth Caritas Pennsylvania

CHCProviders@amerihealthcaritas.com

www.amerihealthcaritaschc.com

1-855-235-5115 (TTY 1-855-235-5112)

pa health & wellness

information@pahealthwellness.com

www.PAHealthWellness.com

1-844-626-6813 (TTY 1-844-349-8916)

UPMC Community HealthChoices

CHCProviders@UPMC.edu

www.upmchealthplan.com/chc

1-844-833-0523 (TTY 1-866-407-8762)

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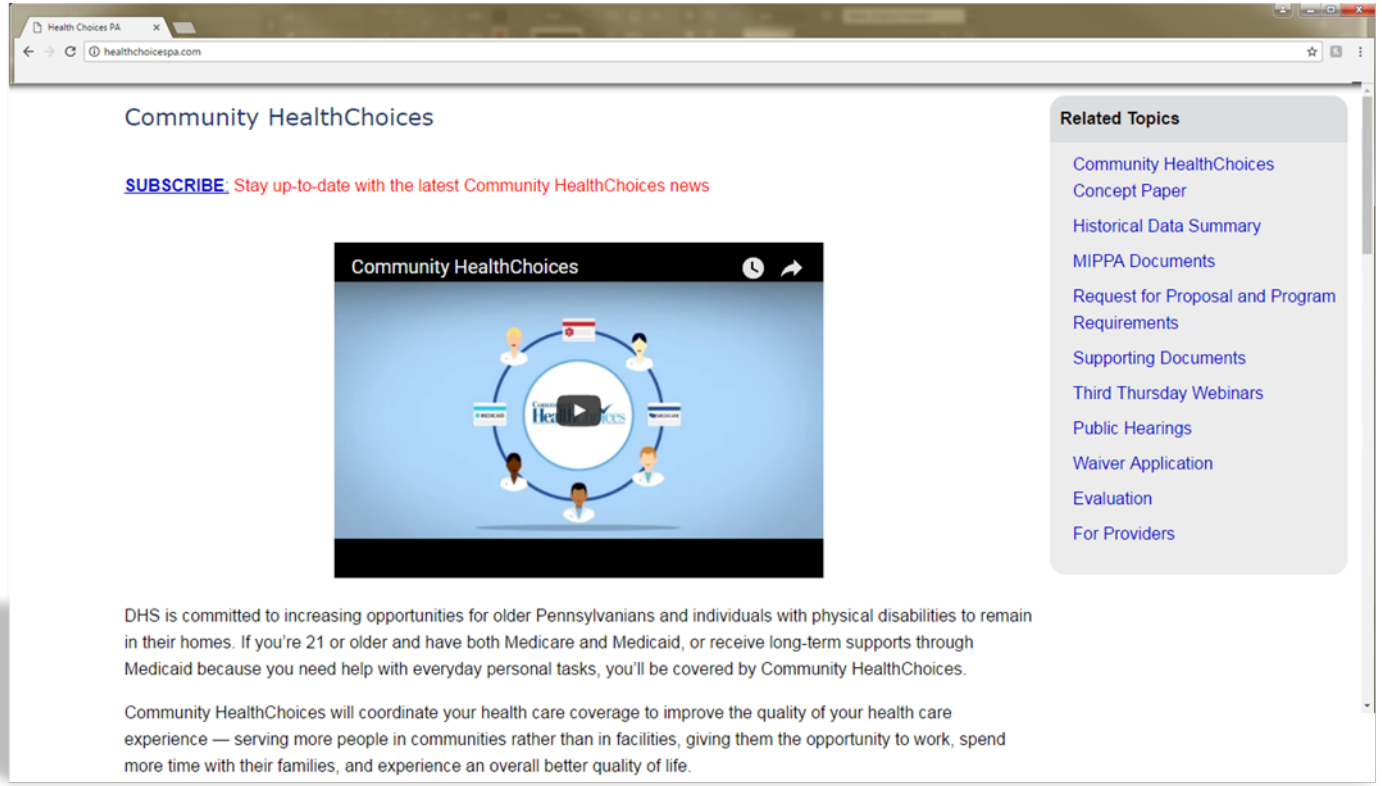
COMMUNICATIONS

CHC WEBSITE



www.HealthChoicesPA.com

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PARTICIPANTS

AWARENESS FLYER

- Mailed five months prior to implementation. Southwest: August 2017

AGING WELL EVENTS

- Participants will receive invitations for events in their area. Southwest: October 2017

SERVICE COORDINATORS

- Will reach out to their participants to inform them about CHC. Southwest: October 2017

NURSING FACILITIES

- Discussions about CHC will occur with their residents. Southwest: October 2017

PRE-TRANSITION NOTICES AND ENROLLMENT PACKET

- Mailed four months prior to implementation. Southwest: September 2017

PROVIDERS

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

CHC ENROLLMENT

INDEPENDENT ENROLLMENT BROKER

Pennsylvania has an independent enrollment broker, known as an IEB that will:

- Walk people through the enrollment & the MCO selection
- Follow-up with each person
- Provide & discuss options (often by asking about current providers & preferences)
- The Participant Call Center will be operational until December, 2018 at **1-844-824-3655** or (**TTY 1-833-254-0690**).

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HOW WILL PEOPLE ENROLL?

- People will have received a notice in October telling them that they are moving into CHC.
- They will also receive an enrollment packet from the IEB telling them about the MCOs and benefit packages.
- Participants will be asked to call the IEB, if the have not received their Enrollment Packet at 1-844-824-3655 or (TTY 1-833-254-0690).
- People will need to take action by choosing an MCO.
- If the participant does not pick an MCO by the set cut-off date, he or she will be automatically assigned to one.
- Participants may change their CHC-MCO at any time.

HOW WILL PEOPLE ENROLL?

- People may get more information by going to www.enrollchc.com or by calling the IEB at 1-844-824-3655 or (TTY 1-833-254-0690).
- They should think about which MCO their providers participate in and what additional services MCOs may offer
- The IEB will walk people through this to help them make a decision.
- People can enroll in an MCO by mailing in their enrollment form or by calling the IEB.

RESOURCE INFORMATION

COMMUNITY HEALTHCHOICES WEBSITE

www.healthchoicespa.com

MLTSS SUBMAAC WEBSITE

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

CHC LISTSERV // STAY INFORMED

http://listserv.dpw.state.pa.us/Scripts/wa.exe?SUBED1=oltl-community healthchoices&A=1

EMAIL COMMENTS TO: RA-MLTSS@pa.gov

PROVIDER LINE: 1-800-932-0939

PARTICIPANT LINE: 1-800-757-5042

INDEPENDENT ENROLLMENT BROKER: 1-844-824-3655 OR

(TTY 1-833-254-0690) open Monday through Friday, 8:00 a.m. to 6:00 p.m.

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QUESTIONS