

Community HealthChoices

O V E R V I E W



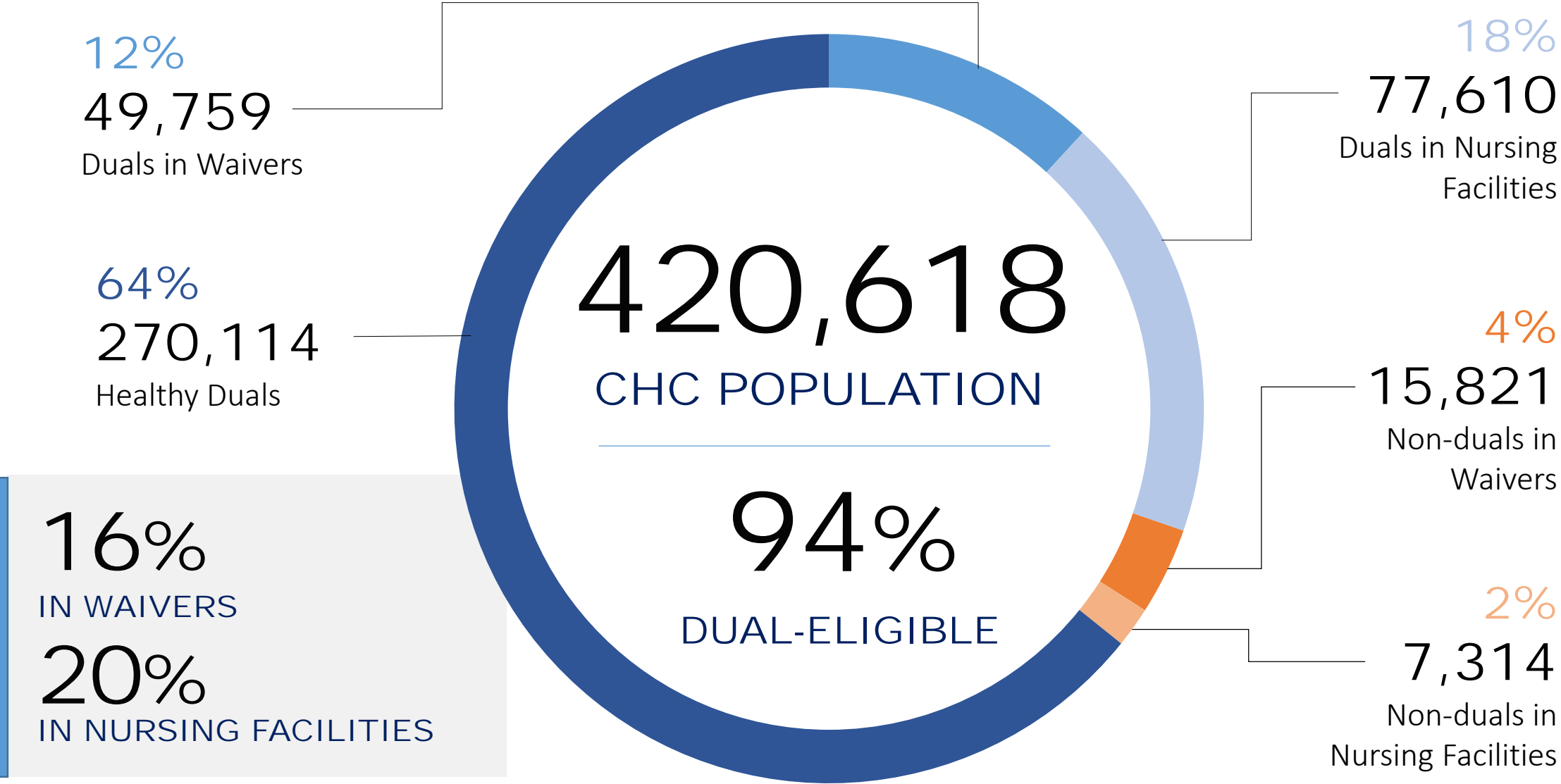
pennsylvania
DEPARTMENT OF HUMAN SERVICES

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).



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

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

CURRENT BARRIERS TO LTSS

- Participants show a tendency to under-plan and under-insure for long-term care until there is a crisis.
- Confusing information about how to receive services.
- The system is difficult to navigate, particularly when transitioning between care delivery systems.
 - ✓ Lack of coordination between primary, acute, and LTSS organizations
 - ✓ Limited coordination between Medicare Special Needs Plans and LTSS organizations
- There is limited availability of long-term care insurance products. Available products limit coverage and are costly.

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 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.

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

HOW PROVIDERS WILL BE PAID FOR SERVICES IN CHC

HOW ARE PROVIDER RATES DETERMINED?

- 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 improved coordination.
- 2018 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.

HOW PROVIDERS WILL BE PAID FOR SERVICES IN CHC

HOW ARE PROVIDER RATES DETERMINED?

- 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.
- DHS is requiring an extended continuity of care provision for personal assistance services and nursing facility services to promote their quality of care and quality of life. To meet this requirement the Department expects CHC-MCOs to pay for these services at the FFS level unless the parties otherwise agree to another payment arrangements.

HOW PROVIDERS WILL BE PAID FOR SERVICES IN CHC

HOW ARE PROVIDERS PAID FOR SERVICES?

- Provider must bill the appropriate CHC-MCO to receive reimbursement for services after January 1, 2018
 - ✓ Services prior to January 1, 2018 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.

HOW PROVIDERS WILL BE PAID FOR SERVICES IN CHC

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.
 - ✓ MCOs will determine payment cycles.
 - ✓ DHS will use monthly claims processing 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 MCO.



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 (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

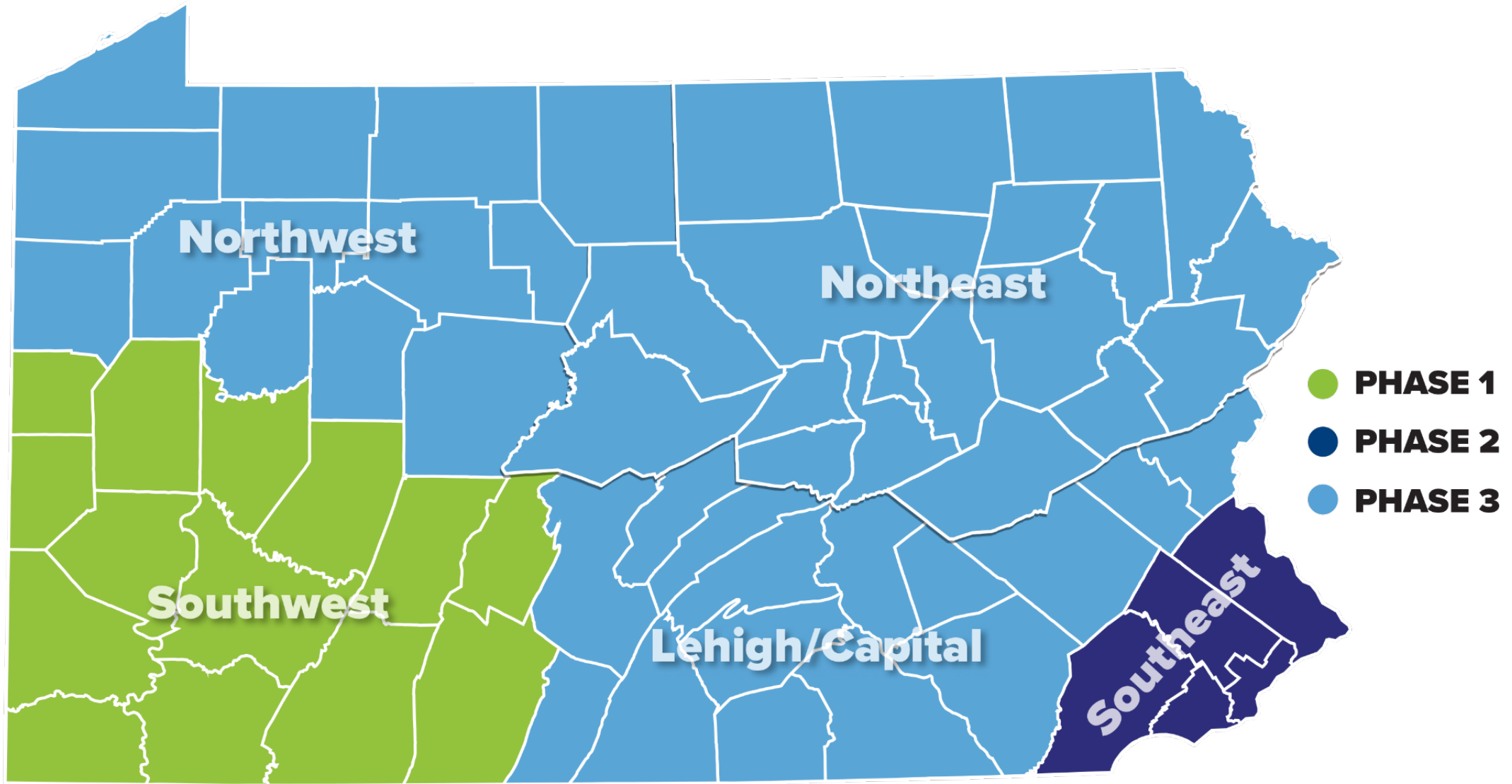
NETWORK ADEQUACY

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 is working with consumers to help develop standards.
- The Department is gathering information to establish a baseline of the number of full-time equivalents (FTEs) (i.e., personal assistance or nursing services) 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.



CHCProviders@amerihealthcaritas.com



information@pahealthwellness.com

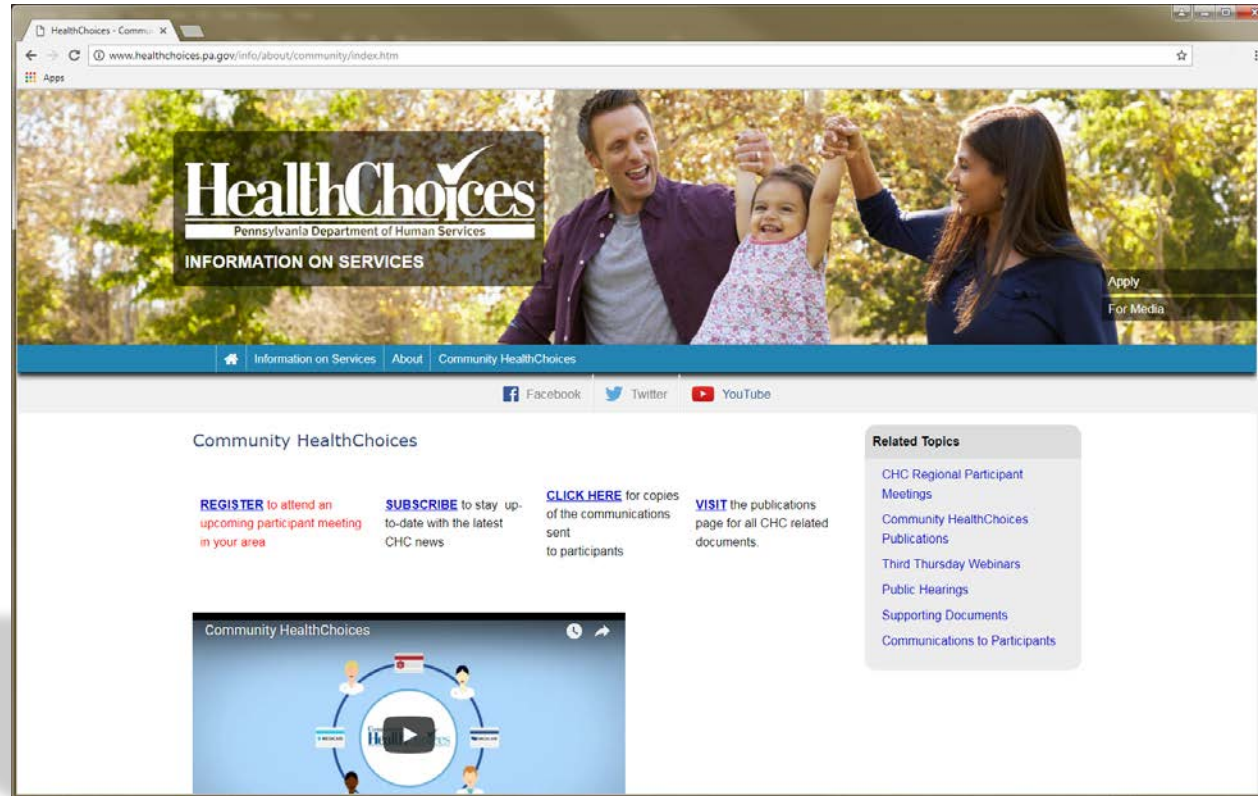
UPMC Community HealthChoices

CHCProviders@UPMC.edu



COMMUNICATIONS

CHC WEBSITE



www.healthchoices.pa.gov

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: August 2017

SERVICE COORDINATORS

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

NURSING FACILITIES

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



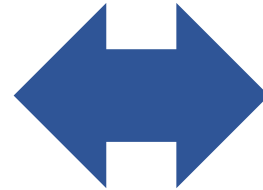


PARTICIPANTS

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?

- Participate in Community HealthChoices Third Thursday webinars to learn more about CHC.
- Participate in stakeholder engagements.
- Read any CHC-related information sent to you by the Department.
- Participate in upcoming educational sessions hosted by the Department.
- Select your MCO by the date identified by the Department.



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.
- 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

COMMUNITY HEALTHCHOICES WEBSITE

www.healthchoices.pa.gov

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-communityhealthchoices&A=1>

EMAIL COMMENTS TO: RA-MLTSS@pa.gov

PROVIDER LINE: 1-833-735-4417

PARTICIPANT LINE: 1-833-735-4416



QUESTIONS