

Community HealthChoices

LEGISLATIVE OVERVIEW

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WHO IS NOT PART OF CHC?

People receiving long-term services & supports in the OBRA waiver

- 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

WHAT IS COMMUNITY HEALTHCHOICES (CHC)?

A Medicaid managed care program that includes physical health benefits and long-term services and supports. The program is referenced to nationally as a managed long-term services and supports program.

WHO IS ELIGIBLE FOR CHC?

- Individuals who are 21 years of age or older and dually eligible for Medicare and Medicaid.
- Individuals who are 21 years of age or older and eligible for Medicaid long-term services and supports because they need the level of care provided by a nursing facility.
 - ✓ This care may be provided in the home, community, or nursing facility.
 - ✓ These individuals may also be eligible for the LIFE program, which is separate from CHC.



WHAT ARE THE GOALS OF CHC?

Enhance opportunities for community-based living.

GOAL 1

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

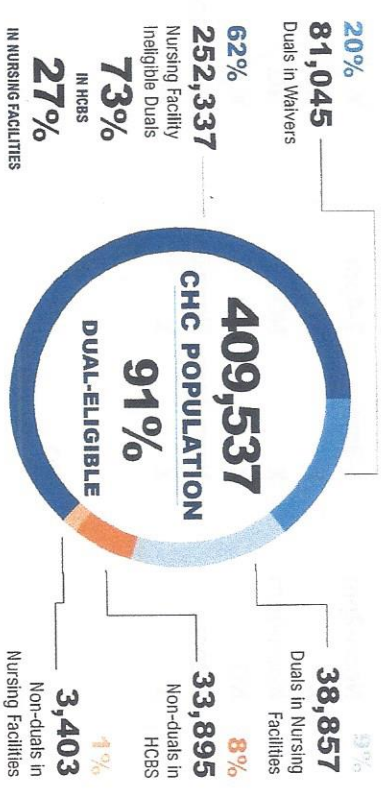
Advance program innovation.

GOAL 5

Increase efficiency and effectiveness.

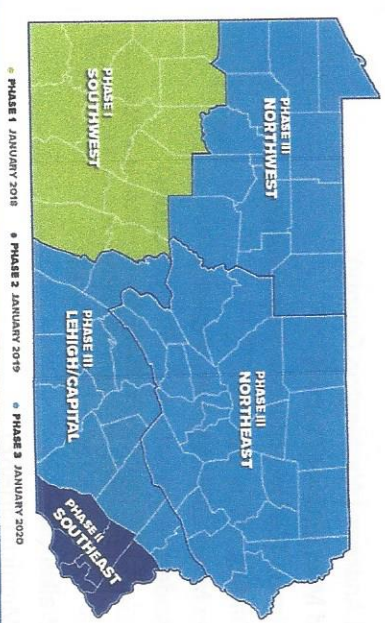


CHC STATEWIDE POPULATION

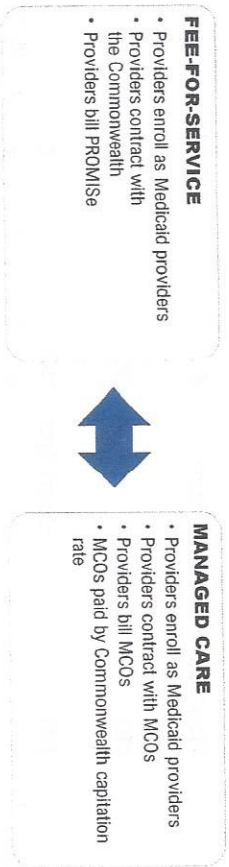


Prior to CHC implementation, 55% of nursing facility eligible participants were in nursing facilities and 45% were in home and community-based services (HCBS).

CHC IMPLEMENTATION TIMELINE



COMPARISON OF FFS VS. MANAGED CARE



COVERED SERVICES

- FOR ALL PARTICIPANTS:**
- Physical Health Services
- All participants receive the Adult Benefit Package.
- This includes services such as:
- Primary care physician
 - Specialist services
- Please note: Medicare coverage continues to be primary payor for dual eligibles.

COVERED SERVICES

FOR PARTICIPANTS WHO QUALIFY FOR LTSS:

HOME AND COMMUNITY-BASED LONG-TERM SERVICES AND SUPPORTS INCLUDING:

- ✓ Adult Daily Living
- ✓ Assistive Technology
- ✓ Behavior Therapy
- ✓ Benefits Counseling
- ✓ Career Assessment
- ✓ Cognitive Rehabilitation Therapy
- ✓ Community Integration
- ✓ Community Transition Services
- ✓ Counseling Services
- ✓ Employment Skills Development
- ✓ Financial Management Services
- ✓ Home Adaptations
- ✓ Home Health Aid Services
- ✓ Home Delivered Meals
- ✓ Non-Medical Transportation
- ✓ Nursing
- ✓ Nutritional Consultation
- ✓ Occupational Therapy
- ✓ Personal Assistance Services
- ✓ Personal Emergency Response System (PERS)
- ✓ Pest Eradication
- ✓ Physical Therapy
- ✓ Job Coaching
- ✓ Residential Habilitation
- ✓ Respite
- ✓ Specialized Medical Equipment
- ✓ Speech and Language Therapy
- ✓ Telecare
- ✓ Vehicle Modifications

LONG-TERM SERVICES AND SUPPORTS IN A NURSING FACILITY

COVERED SERVICES

TRANSPORTATION SERVICES:

- All CHC participants have access to emergency and non-emergency medical transportation.
- Participants 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 coordinate transportation for their residents.
- Nursing facility clinically eligible 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 long-term services and supports as specified in the Participant's Person-Centered Service Plan.
 - 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 ALL PARTICIPANTS:

Behavioral Health Services

- All participants 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

IDENTIFYING NEEDS

SCREENING, COMPREHENSIVE NEEDS ASSESSMENT & REASSESSMENT

- CHC-MCOs must:
 - screen each new participant who are community well duals within 90 days of the start date
 - conduct a comprehensive needs assessment of every participant who is determined nursing facility clinically eligible
 - 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 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

SERVICE COORDINATION

- Every participant receiving LTSS has a service coordinator.
- The service coordinator coordinates Medicare, LTSS, physical health services, and behavioral health services.
- They 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 facilitates the person-centered planning team.
- Each participant has a person-centered planning team that includes their doctors, service providers, and natural supports.

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SERVICE PLANNING

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 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.

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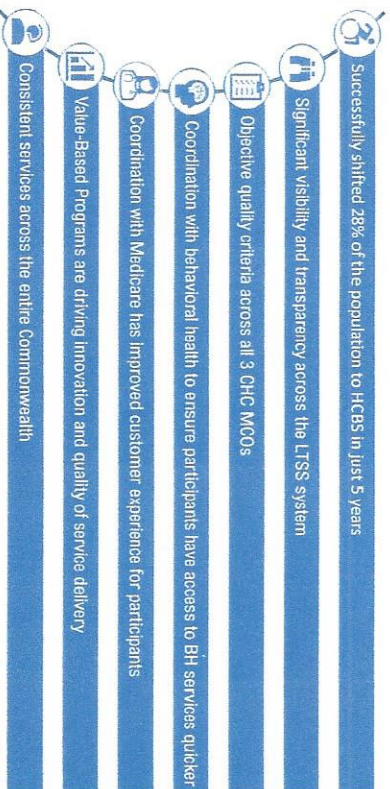
COORDINATION WITH MEDICARE

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 continue to have all of the Medicare options, including Original Medicare and Medicare Advantage managed care plans.
- 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 is the primary payor for any service covered by Medicare. Providers bill Medicare for eligible services prior to billing Medicaid.

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THE SUCCESS OF CHC



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MEDICAID REDETERMINATIONS

Beginning April 1, the continuous eligibility requirements for the public health emergency (PHE) will end. While the state has been doing redeterminations throughout the PHE, over 98,000 participants have either not returned their redetermination applications or are no longer eligible for CHC.

- The MCOs are working closely with the Department to communicate the upcoming PHE unwinding.
- Efforts to communicate and assist participants include:
 - Letters, postcards, newsletters, and emails
 - Phone calls and text messages
 - Minority outreach efforts

MCO GOVERNMENT RELATIONS CONTACTS

The MCOs are available to assist with any issues or questions you may have regarding CHC. Please do not hesitate to contact one of the Government Relations professionals from the respective plans:

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QUESTIONS