

Community Health Choices: Lessons Learned in Phase 1

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DHS Messages – Third Thursday Webinar

- DHS continues to indicate that they are on target for roll out of Phase 2 beginning January 2019
- Priorities are:
 - No interruption in participant services
 - No interruption in provider payment
 - Successful launch of Phase 1

<http://www.healthchoices.pa.gov/info/resources/publications/community/third-thursday-webinars/index.htm>

Pennsylvania's Goals for the Program

- Enhance opportunities for community based services
- Strengthen healthcare and long term services and support delivery systems
- Allow for new innovations
- Promote the health, safety and well-being of enrolled participants
- Ensure transparency, accountability, effectiveness and efficiency of the program

What is MLTSS?

- An arrangement between state Medicaid programs and contractors through which the contractors receive capitated payments for LTSS provided to elderly individuals and people with disabilities, including persons with mental health and substance abuse conditions, who are enrolled in Medicaid.
- MLTSS programs are accountable for the delivery of services and supports that meet quality and other standards set in the contracts.

MLTSS Goals

- Rebalance the provision of LTSS from institutions to home and community based settings.
- Increase the integration of primary care, behavioral health services and LTSS – encourage providers to work together in delivering person centered care.
- Improve outcomes and quality of care.
- Note: As of January 2018, 24 states have implemented MLTSS programs for some or all of their populations who need NF level of care.

Priority Issues

- Enrollment
- Ensuring timely payments to nursing facilities.
- MCOs understand the complexities of nursing facility billing
 - ▶ Patient pay
 - ▶ Medicare
 - ▶ Penalty periods, etc.



Who is Affected?

- Dual eligible individuals
- MA recipients residing in a Nursing Facility on MA benefit
- MA recipients receiving long term services and support through one of the Medicaid home and community based waiver programs
- LIFE program will continue to be an option in addition to Community HealthChoices (CHC)

MA Eligibility

- Clinical Eligibility
 - Conducted by Aging Well –AAA entity
 - Functional Eligibility Determination (FED) form
 - ▶ New form–subset of the InterRAI-HC Comprehensive Assessment plus PA specific questions
 - ▶ Completed on computer – includes the questions necessary to determine NFCE
 - ▶ Shortens timeframe
 - ▶ Ensures consistency across assessors

MA Eligibility

- Financial Eligibility
 - CAOs continue to determine financial eligibility
 - Use of COMPASS vs Paper Applications
 - Role of Independent Enrollment Broker

Enrollment in CHC-MCO

- Role of IEB
 - Responsible for educating, answering questions, discussing options and providing decision making support for selection of a plan
- Role of NF
 - Educate residents and families
 - Cannot make recommendations or steer residents to a certain plan

Enrollment in CHC-MCO

- Enrollment packets will be distributed for residents to select a plan by a date certain or the resident will be auto enrolled. Enrollment options are via mail, telephone, email or online at www.enrollchc.com
- Change plan anytime
 - Dating rules – before or on the 15th of the month effective first day of the following month – after the 15th of the month effective first day of the second month after selection made

Your Health Plan Choices

Added benefits: All plans have **added** benefits. Use this chart to compare the added benefits and services each health plan offers:



Adult dental

- Oral hygiene kit for qualified participants

Adult vision

- No extra services

Phone services

- Free Smartphone with 350 minutes of talk and unlimited text

Wellness programs

- Home provider visits, lab draws and testing for qualified participants
- Video visits with care manager
- Keys to Your Care® maternity program
- Box fan for qualified participants

Health and wellness gift cards

Other benefits

- **In home supports and services to help qualified participants avoid nursing home stay**
- **Welcome Home Benefit** helps qualified participants with LTSS move from nursing facility to home up to \$6,000, which can be used for rental assistance
- **Caregiver programs offer education, respite services and supports**



Adult dental

- No extra services

Adult vision

- No extra services

Phone services

- ConnectionsPlus® free cell phones

Wellness programs

- Gift cards for participating farmers market
- Post-acute: 14 days of home delivered meals
- Post-acute: 14 days of respite care
- Caregiver access and supports
- Health library

Other benefits

- CentAccount Healthy Rewards purchasing card that can be used at authorized retailers to get health-related items
- Non-medical transportation services
- 90-day prescription refill
- \$5000 financial support to move from a nursing home to the community
- Start Smart for Your Baby

UPMC Community HealthChoices

Adult dental

- \$500 yearly allowance for dental care

Adult vision

- \$100 yearly allowance for glasses or contacts
- One fitting every 12 months

Phone services

- Free Safelink Android Smartphone with 350 minutes of talk and unlimited text

Wellness programs

- Free health coaching services
- Free 24/7 video meetings with UPMC providers
- Online program to ease stress
- UPMC maternity program

Other benefits

- Community-based services and supports for qualified participants without LTSS needs
- Seniorlink caregiver allowance and coaching
- Support during yearly Medical Assistance eligibility review
- \$6000 yearly allowance to leave a nursing home and move back into the community
- Temporary rental assistance if leaving nursing facility and on rental assistance waiting list

Long-term services and supports (LTSS)

If you are eligible to receive Medicaid long-term services and supports through a Medicaid home and community-based waiver or you qualify for Medicaid nursing facility services, you also get these long-term services and supports.

- Adult daily living services
- Assistive technology and home adaptations
- Behavior therapy
- Benefits counseling
- Career assessment
- Cognitive rehabilitation therapy
- Community integration and transition
- Counseling
- Employment skills development
- Financial management services
- Home delivered meals
- Home health, including physical, occupational, and speech and language therapies
- Home health aide and nursing
- Job coaching and help looking for a job
- Non-medical transportation
- Nutritional counseling
- Participant-directed community supports
- Participant-directed goods and services
- Personal assistance services
- Personal emergency response system (PERS)
- Pest control
- Residential and structured day habilitation
- Respite care
- Specialized medical equipment and supplies
- TeleCare (doctor by video)
- Vehicle modifications



Questions? Visit www.enrollchc.com or call us at 1-844-824-3655 (TTY: 1-833-254-0690). The call is free!

You can get this information in other languages or formats, such as large print or audio.

For participants who can get physical and behavioral health benefits, and are eligible for Medicaid long-term services and supports (LTSS)



1-855-235-5115
TTY: 1-855-235-5112

www.amerihalthcaritaschc.com



1-844-626-6813
TTY: 1-844-349-8916

www.PAHealthWellness.com

UPMC Community HealthChoices

1-844-833-0523
TTY: 1-866-407-8762

www.upmchealthplan.com/chc

Co-pays:
Ambulance · Per trip \$ 0
Dental care \$ 0
Inpatient hospital · Per day \$ 3 · Maximum with limits \$ 21
Medical centers · Ambulatory surgical center \$ 3 · Federal Qualified Health Center or Regional Health Center \$ 0 · Independent medical/surgical center \$ 3 · Short procedure unit \$ 3
Medical equipment · Purchase Sliding scale · Rental \$ 0
Medical visits · Certified nurse practitioner \$ 0 · Chiropractor \$ 1 · Doctor \$ 0 · Optometrist \$ 0 · Podiatrist \$ 1
Outpatient hospital · Per visit – outpatient surgical, except maternity, \$ 3 · Per visit – non-surgical or diagnostic \$ 0
Prescriptions · Generic \$ 1 · Brand name \$ 3
X-rays · Per service \$ 1

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Physical and behavioral health benefits

All CHC participants can get **physical** and **behavioral** health benefits. Your **physical** benefits are listed below. A behavioral health managed care organization will provide your **behavioral** health benefits.

You will get these **physical** health benefits from your CHC health plan:

- Certified registered nurse practitioner services
- Chiropractic services
- Clinic services
- Crisis services
- Contact lenses and eyeglass frames and lenses for persons with aphakia (no eye lens)
- Dental care services
- Durable medical equipment
- Emergency room and ambulance services
- Family planning services and supplies
- Federally qualified health center services and rural health clinic services
- Home health services
- Hospice services
- Inpatient hospital services
- Laboratory services
- Maternity care from a doctor, certified nurse, midwife or birth center
- Medical supplies
- Mobile mental health treatment
- Non-emergency transportation to and from covered services
- Nursing facility services
- Nutritional supplements
- Optometrist services
- Outpatient hospital services
- Peer support services
- Podiatrist services
- Prescription drugs
- Primary care practitioner (PCP) and physician services
- Prosthetics and orthotics (orthopedic shoes and hearing aids are not covered)
- Renal dialysis services
- Physical, occupational, speech, and rehabilitative therapy and rehabilitative services, when provided by a hospital, outpatient clinic or home health provider
- Quitting smoking or tobacco use
- X-rays, MRIs and CTs

Auto Enrollment Criteria

- First, if on the Enrollment Date the individual is residing in a NF that is a network provider in only one CHC-MCO, the individual will be enrolled in that CHC-MCO.
- Second, if the individual is enrolled in a D-SNP, the individual will be enrolled in the CHC-MCO that is aligned with that D-SNP.
- Third, if the individual is transferring from HealthChoices and is a member of a Physical Health HealthChoices MCO that is a CHC-MCO, the individual will be enrolled in that CHC-MCO.
- Last, if the individual's PCP is a network provider with only one CHC-MCO, the individual will be enrolled in that CHC-MCO.

Selecting an MCO

- Online Training For NF Staff available
- Network providers
 - Primary Care Physician
 - Ancillary providers
 - Nursing facility



Who Pays

- MA pending
 - Physical HealthChoices admission
 - Medicare or Private pay admission – spend down
 - CHC-MCO admission from community

Impact on Operations

- Independent Enrollment Broker (IEB)
 - Choice counseling
- CHC-MCO Service Coordinator
 - How to integrate them into existing care planning process
 - Prior Authorizations, etc.
- MA Application Process

Impact on Operations

- MDS data
 - The Department intended to require that all participants in CHC receive a comprehensive assessment using the InterRAI- HC assessment form.
 - Plans and the associations pushed back, DHS agreed to allow the plans to use the MDS data -challenge is how to share the MDS data with the plan the resident is enrolled in.

Nursing Facility Payments

- DHS initial plan was to require NFs to negotiate payment rates with each of the MCO plans
- An agreement with the Department to provide a safety net for NFs – the agreement provides for:
 - 36-month rate floor
 - 18-month any willing provider
 - Readiness review claims testing

Nursing Facility Payments

- DHS cannot direct payments- All part of CHC-MCO Contracts
 - Disproportionate Share Payments
 - Ventilatory/Trach Supplemental Payments
 - Assessment Supplemental Payments
 - ▶ Appendix 4
- Legislative authorized payments
 - HAI Surcharge
 - MA Day One Incentive Payments



Covered Services

- Covered Services — Services which the CHC-MCO is required to offer to Participants as specified in Exhibit A of the CHC-MCO Agreement
- The CHC-MCO must provide Medically Necessary PH services and LTSS in accordance with the requirements of the CHC MCO Agreement with DHS
- The CHC-MCO must require that Medical Necessity determinations of Covered Services be documented in writing. For NF care, this is the Assessment.

Covered Services

- The CHC-MCO must establish a program exception process, reviewed and approved by the Department, whereby a Provider or Participant may request coverage for items or services, which are included in the Participant's benefit package but are not currently listed on the MA Program Fee Schedule.
- The CHC-MCO may provide Expanded Services or Value-Added Services with prior written approval by the Department. Best practice approaches to delivering Covered Services are not Expanded Services or Value-Added Services.

Referrals And Covered Services

- The CHC-MCO must establish and maintain a referral process to effectively utilize and manage the care of its Participants.
- The CHC-MCO must provide coverage of prescription and OTC medicines for Dual Eligibles that are not otherwise covered by a Medicare Part D prescription drug plan.
- The CHC-MCO is responsible for Emergency Services including those categorized as mental health or drug and alcohol services.
- The CHC-MCO must cover Post-Stabilization Services.

Covered Services

- The CHC-MCO must provide Participants under evaluation as possible victims of abuse or neglect and who present for physical examinations for determination of abuse or neglect, with such services.
- The CHC-MCO must provide Hospice and use certified Hospice Providers in accordance with 42 C.F.R. Subpart G.
- The CHC-MCO must pay for transplants to the extent that the MA FFS Program pays for such transplants.

Transportation

- The CHC-MCO must provide all Participants with Medically Necessary emergency ambulance transportation and Medically Necessary non-emergency ambulance transportation.
- The CHC-MCO may provide non-medical transportation to other Participants at its own discretion and own cost.
- Upcoming Transportation Summit.

NF Services

- The CHC-MCO is responsible for payment for Medically Necessary NF services, including bed hold days and up to fifteen (15) days per hospitalization and up to thirty (30) Therapeutic Leave Days per year if a Participant is admitted to an NF or resides in an NF at the time of Enrollment.
- The CHC-MCO must, in coordination with the Department, monitor for completion of all NF-related processes, including but not limited to: PASRR process, specialized service delivery, Participant's rights, patient pay liability, personal care accounts, or other identified processes.

Resources

- PACAH <http://www.pacahpa.org/Pages/Resources.aspx>
- DHS ListServ – sign up!!
- DHS Website
<http://www.healthchoices.pa.gov/info/about/community/>
- Third Thursday Webinars
<http://www.healthchoices.pa.gov/info/resources/publications/community/third-thursday-webinars/index.htm>
- Cindy Haines chaines@postschell.com
 - 717-612-6051



DHS Messages

- Come armed with questions that directly impact your facility and those you serve
- Events to be scheduled in the SE for CHC
- Provider Education Summit in the SE
- If you want to be a CHC provider, contact the chosen MCOs

www.dhs.pa.gov/citizens/communityhealthchoices/

Before The Contract

- Develop relationships
- Do:
 - Reach out to the MCOs
 - ▶ CHC-MCO CONTACT INFORMATION
 - AmeriHealth Caritas | CHCProviders@amerihealthcaritas.com
www.amerihealthcaritaschc.com - 1-855-235-5115 (TTY 1-855-235-5112)
 - Pennsylvania Health and Wellness (Centene) |
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)
 - Find the right internal representative
 - Arm the negotiator with all the necessary information
- Don't:
 - Be an ostrich



Before The Contract

- Be prepared
 - Know your market
 - Understand the provider network
 - Document costs
 - Demonstrate your value
 - Pick Your Battles
 - ▶ What are your most important issues?
 - ▶ What are your deal breakers?

Down To Business

- Read incorporated materials carefully
 - ▶ Look for “incorporated by reference,” “you will be required to comply with” . . .
 - ▶ Beware of references to other documents outside of the contract (or online) that may change without notice
- Don’t fail to read reference material

Down to Business

- Familiarize yourself with the Provider Manual/Handbook
- Identify how it is changed by the MCO
- Understand that the Manuals are not really subject to negotiation but raise concerns
- Read the Definitions section
- Realize that how terms are defined affects the entire agreement
- Raise concerns about inaccurate terms

Regulatory Compliance

- Do understand your regulatory responsibilities:
 - Expect regulatory language related to:
 - ▶ Exclusions
 - ▶ Privacy and confidentiality
 - ▶ Stark and Anti-kickback
- Don't:
 - Agree to contractual terms that:
 - ▶ Are more strident than the actual regulation or other requirement
 - ▶ Are not your responsibility
 - ▶ Require you to agree to something you can't control

Procedures

- Review your admissions and discharge procedures
- Compare this to what is required under the MCO proposed contract
- Identify the roles of you, the MCO, the supports coordinator. Who are the primary contacts?
- Don't wait until you are admitting or discharging a resident to discuss
- Credentialing – Rely on the Federal and State Medicare and Medicaid and other provider participation standards

Procedures

Documentation

- Check what is required
- Ask where the templates/forms are
- Do think about how this documentation fits into your current business processes
- Don't expect uniformity across payors

Procedures

Billing

- Identify how things will change
- Question whether there are checks and balance
- Understand how you will address any disputes
- Don't wait for a problem to understand the process

Procedures

Payment

- Clarify important timing issues
- Assure that you are working from the same definitions (e.g. clean claims, prior authorizations)
- Assess the co-insurance, patient pays and deductibles processes, if any
- Assess resident impact

QUESTIONS?

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