COMMUNITY HEALTH CHOICES AND THE NEW FEDERAL MANAGED CARE RULES

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Community HealthChoices

- Mandatory Medicaid Managed Care Program
- Long-Term Services and Supports (LTSS).
- We will address:
  - The Legal Framework
  - The Structure of CHC
  - CHC Program Features and Outreach Efforts
  - CHC Launch Update
  - The Complaints and Grievance Process

Community HealthChoices

- Traditional Indemnity
  - Little or no restriction on provider choice
  - Utilization is generally not restricted and no care coordination
  - No contracted fees
- Managed Care
  - Limits provider choice to varying degrees
  - Controls utilization to varying degrees, and coordinates care
  - Pays contracted fees to providers

State and Federal Legal Framework

State Authority to Implement

- Pennsylvania Human Services Code – general authority - 62 P.S. § 443.5
- Brinson v. Dep't of Public Welfare, 641 A.2d 1246 (Pa. Cmwlth. 1994).

State and Federal Legal Framework

State Law relating to Managed Care

- Health Maintenance Organizations Act. 40 P.S. §§ 1551 - 1568.
- The Insurance Act of 1921, *as amended by*, 40 P.S. § 764a; and 40 P.S. §§ 991.2102 - 991.2194.
- Department of Insurance Regulations and Statements of Policy. 31 Pa Code Chapters 301 and 303 and 31 Pa. Code Chapter 152.
- Department of Health Regulations. 28 Pa. Code Chapter 9

State and Federal Legal Framework

Federal Financial Participation

- Waivers
  - 1915(b)
  - 1915(c)
- Regulations
  - New Managed Care - 81 F.R. 27499 (May 6, 2016).
  - HCBS – 42 CFR Part 441

State and Federal Legal Framework

New Managed Care Regulations - 81 F.R. 27499 (May 6, 2016)
42 CFR Part 438.

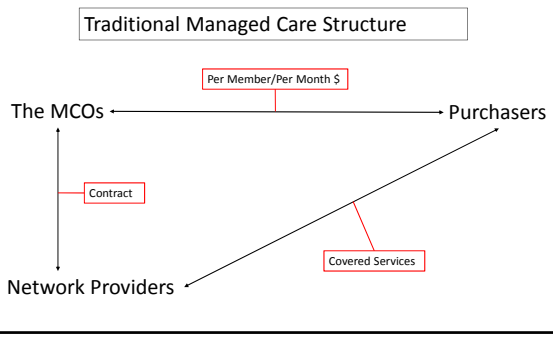
Impetus for new rule was growth in Medicaid Managed Care. 81 FR at 27500.

State and Federal Legal Framework

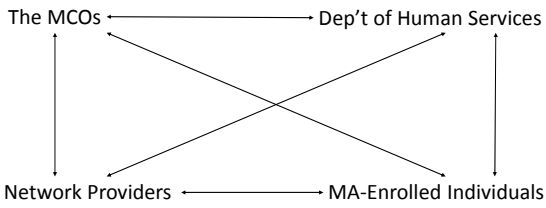
New Managed Care Regulations - 81 F.R. 27499 (May 6, 2016)
42 CFR Part 438.

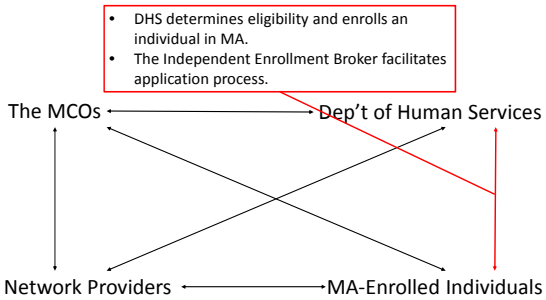
- Stated Goals:
  - Support state delivery system reform
  - Improve quality of care, health care outcomes and the beneficiary experience
  - Effectively manage costs
  - Promote effective use of data in overseeing managed care
  - Align with other sources of coverage
  - Strengthen actuarial soundness and accountability of payments rates.

81 FR at 27501.



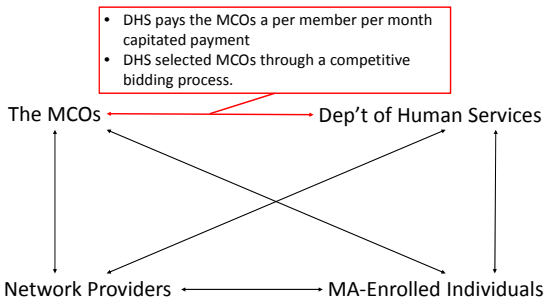
CHC Structure and Key Issues





DHS Determines Eligibility.

- CHC does not affect the rules to determine MA or Medicare eligibility.
- DHS will enroll an MA beneficiary in CHC if he or she:
  - Is twenty-one years of age or older; and
  - Either:
    - Requires LTSS; or
    - Is also enrolled in Medicare.



DHS selected MCOs through a competitive bidding process.

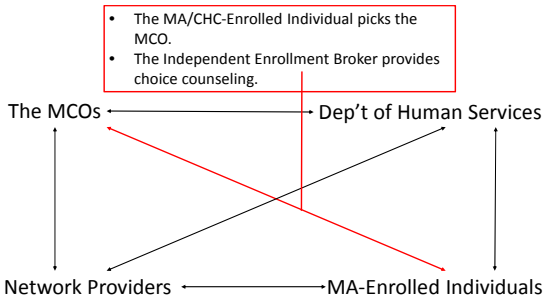
Five Geographic Zones

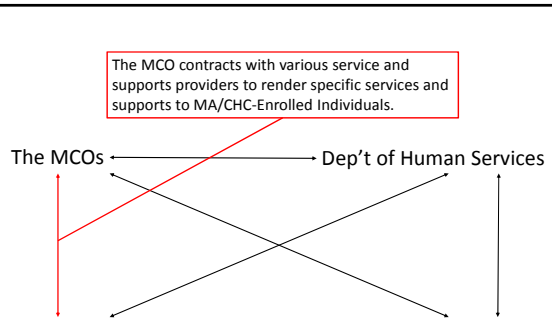
DHS selected MCOs through a competitive bidding process.

- Selected the same three offerors for all five zones:
  - Pennsylvania Health & Wellness, Inc.;
  - Vista Health Plan, Inc. (operating as "Amerihealth Caritas"); and
  - UPMC For You, Inc. (UPMC).
- Bid protests – Secretary affirmed in two cases:
  - UnitedHealthcare of Pa., Inc. v. Dep't of Human Services, 172 A.3d 98 (Pa. Cmwlth. 2017); and
  - Gateway Health Plan, Inc. v. Dep't of Human Services, 172 A.3d 700 (Pa. Cmwlth. 2017).

DHS pays the MCOs a per member per month capitated payment

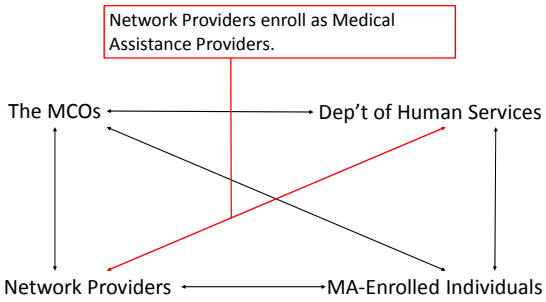
- **Actuarially Sound**. 42 CFR § 438.4; and 81 FR at 27566 – 27566.
- **Certified**. 42 CFR § 438.7.
- **Identify data.** Id.
- **Rate Cells.** 42 CFR §§ 438.2 and 438.4(b)(4); 81 FR at 27565
  - CHC - rate cells based on four attributes: (1) geography; (2) clinical eligibility; (3) status of enrollment in MA and Medicare; and (4) age groups
- **Risk Mitigation.**





The MCO contracts with various service and supports providers to render specific services and supports to MA-Enrolled Individuals

- Special Nursing Facility, Personal Assistance Services and Respite Services Payment "Limits."
- Continuity of Care
  - General Rule – 60 days
  - Residing in an NF on Implementation Date – Allowed to Stay
  - Individuals receiving HCBS on Implementation Date – 180-day Continuation



Network Providers enroll as Medical Assistance Providers

- Network providers must comply with all applicable MA certification and state licensing laws and policies.
- Nursing Facilities:
  - MA certification requirements found at 42 CFR Part 483.
  - Participation Review Process at 55 Pa. Code §§ 1187.161 – 1187.177.

Implementation Schedule

Phase One – effective January 1, 2018: Southwest Zone
Phase Two – effective January 1, 2019: Southeast Zone
Phase Three – effective January 1, 2020: Lehigh/Capital Zone; Northwest Zone; and Northeast Zone

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).

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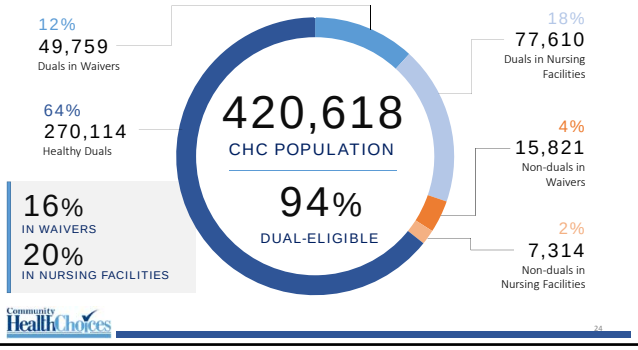

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WHO IS NOT PART OF CHC?

- 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

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.

CHC Program Design Components

Extensive Stakeholder Engagement in Program Design:

- Publication of Discussion Document and Concept Paper of the original program design for public comment
- Six statewide listening sessions
- Publication of the draft request for proposal for public comment
- Development of an advisory committee designed with a cross-section of participants to support program design and oversight
- Monthly webinars about program components
- Bi-weekly provider communications and in-person provider outreach sessions
- Participant outreach through mailings and in-person sessions
- Participant hotlines independent of CHC-MCOs

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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WHY MAKE THE CHANGE?

Managed care organizations will reduce barriers & challenges by:

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

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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.

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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.

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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.

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CHC LAUNCH UPDATE

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2018 Community HealthChoices SW GOALS

- **ASSURING NO PARTICIPANT SERVICE INTERRUPTIONS**
- **ASSURING NO INTERRUPTION IN PROVIDER PAYMENT**
- **SUCCESSFUL LAUNCH FIRST PHASE**

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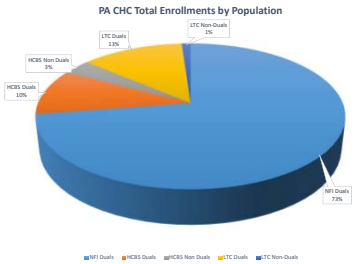
CHC SOUTHWEST JANUARY (Population Distribution)



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CHC SOUTHWEST JANUARY (Age Distribution)

Population	Over 60	Under 60
NFI Duals	51.2%	48.8%
HCBS Duals	69.4%	30.6%
HCBS Non Duals	33.3%	66.7%
NF Duals	94.7%	5.3%
NF Non-Duals	45.0%	55.0%
Total Population	57.9%	42.1%

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Complaints and Grievances

- The MCO's Process to Resolve Participant Disputes
- Governing Regulations
  - Federal - 42 CFR Part 438, Subpart F
  - State - 28 Pa. Code §§ 9.701 – 9.711
- Modified the existing Complaint and Grievance process in HealthChoices only if in direct conflict with the new federal regulations

Complaints and Grievances

Changes to existing Complaint and Grievance process

- Second-level complaint review eliminated for some types of complaints and all grievances
  - 42 CFR §§ 438.402(b), (c)
- Fair hearing may not be requested until Complaint and Grievance process exhausted
  - 42 CFR §§ 438.402(c), 438.408(f)(1)

Complaints and Grievances

Definition of Complaint

A dispute or objection regarding a participating health care provider or the coverage, operations or management of a CHC-MCO, which has not been resolved by the CHC-MCO and has been filed with the CHC-MCO or with the Department of Health ("DOH") or the Pennsylvania Insurance Department ("PID").

Complaints and Grievances

Examples of Complaints

- a denial because the requested service or item is not covered
- the failure of the CHC-MCO to provide a service or item in a timely manner;
- the failure of the CHC-MCO to decide a Complaint or Grievance within the specified time frames;
- a denial of payment by the CHC-MCO after a service or item has been delivered without authorization by a provider not enrolled in the Medical Assistance Program;
- a denial of payment by the CHC-MCO after a service or item has been delivered because the service or item is not a covered service for the Participant; or
- a denial of a participant's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other Participant financial liabilities
- participant dissatisfaction with a provider or the quality of care received

Complaints and Grievances

Definition of Grievance

A request to have a CHC-MCO reconsider a decision concerning the **medical necessity and appropriateness of a covered service.**

A Grievance may dispute a CHC-MCO decision to:

- deny, in whole or in part, payment for a service or item;
- deny or issue a limited authorization of a requested service or item;
- reduce, suspend, or terminate a previously authorized service or item;
- deny the requested service or item but approve a different service or item; and
- deny a request for a benefit limit exception

Complaints and Grievances

General Rules for Both Complaints and Grievances

- May be filed orally or in writing
  - If oral, CHC-MCO must commit Complaint to writing if participant does not confirm in writing and provide to participant for signature at any point in the Complaint process
  - If in writing, Request Form or letter may be mailed or faxed
- May be filed by the participant or by the participant's representative or provider with the participant's written consent

Complaints and Grievances

General Rules for Both Complaints and Grievances

Expedited review

- Available if CHC-MCO determines or participant's provider certifies that standard time would jeopardize participant's life, physical or mental health, or ability to attain, maintain, or regain maximum function
- CHC-MCO must inform participant that certification is needed and make reasonable effort to obtain certification from provider
- If provider certification not received within 72 hours of request, CHC-MCO must decide Complaint or Grievance within the standard time frame, with written notice to participant that expedited review denied

Complaints and Grievances

First Level Complaints – Time for filing

- File within 60 days of any of the following:
  - the date the participant receives the CHC-MCO decision notice
    - denial because not covered
    - payment denial after service provided
    - denial of participant request to dispute financial liability
  - the date an untimely service should have been provided
  - the date a Complaint or Grievance should have been decided
- No deadline for filing to dispute any other issue (for example, participant dissatisfaction with a provider)

Complaints and Grievances

First Level Complaints – Decision-making

- Review committee
  - One or more MCO staff who were not involved in and do not work for someone involved in the subject of the Complaint
  - If Complaint involves a clinical issue, committee must include a licensed physician, who must decide the Complaint
- Decide and send written notice within 30 days, unless extended by up to 14 days at request of participant

Complaints and Grievances

First Level Complaints – Options After Decision

Participant may request a Fair Hearing, an External Review, or both, if the Complaint is about one of the following:

- a denial because the requested service or item is not covered
- the failure of the CHC-MCO to provide a service or item in a timely manner;
- the failure of the CHC-MCO to decide a Complaint or Grievance within the specified time frames;
- a denial of payment by the CHC-MCO after a service or item has been delivered without authorization by a provider not enrolled in the Medical Assistance Program;
- a denial of payment by the CHC-MCO after a service or item has been delivered because the service or item is not a covered service for the Participant; or
- a denial of a participant's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other Participant financial liabilities

Participant may request a second level Complaint review for all other Complaints

Complaints and Grievances

Second Level Complaints

Time for Filing

- File within 45 days from the date the participant receives the first level Complaint decision

Decision-making

- Review committee
  - Three or more individuals who were not involved in and do not work for someone involved in subject of the Complaint
  - At least one-third of the committee may not be employees of the CHC-MCO or related entity
  - If Complaint involves a clinical issue, committee must include a licensed physician, who must decide the Complaint
- Decide and send written notice within 45 days

Complaints and Grievances

Second Level Complaints – Options After Decision

- Participant may request External Review
- Participant may not request a Fair Hearing

Complaints and Grievances

Grievances

- File within 60 days from the date the participant receives the CHC-MCO decision notice

Complaints and Grievance

Grievances

- Review committee
  - Three or more individuals who were not involved in and do not work for someone involved in the subject of the Grievance
  - At least one-third of the committee may not be employees of the MCO
  - Must include a licensed physician, who must decide the Grievance
- Decide and issue written notice within 30 days, unless extended by up to 14 days by the participant
- Participant may request a Fair Hearing or an External Review or both

Complaints and Grievances

Fair Hearing and External Review

- Filing Deadlines
  - Fair Hearing – within 120 days from the mail date on the CHC-MCO Grievance decision notice
  - External Review – within 15 days from the date the participant receives the CHC-MCO decision notice
    - DOH and PID control the external review process and communicate with the participant about that process. *See* 28 Pa. Code § 9.704.
- Time frame for decision
  - Fair Hearing – within 90 days from the date of the first level Complaint or Grievance, not including the number of days before the participant requests the fair hearing
  - External Review – within 60 days from the date of the request for External Review