

Community HealthChoices

Pennsylvania's Approach to MLTSS Design as a Non-Duals Demonstration State

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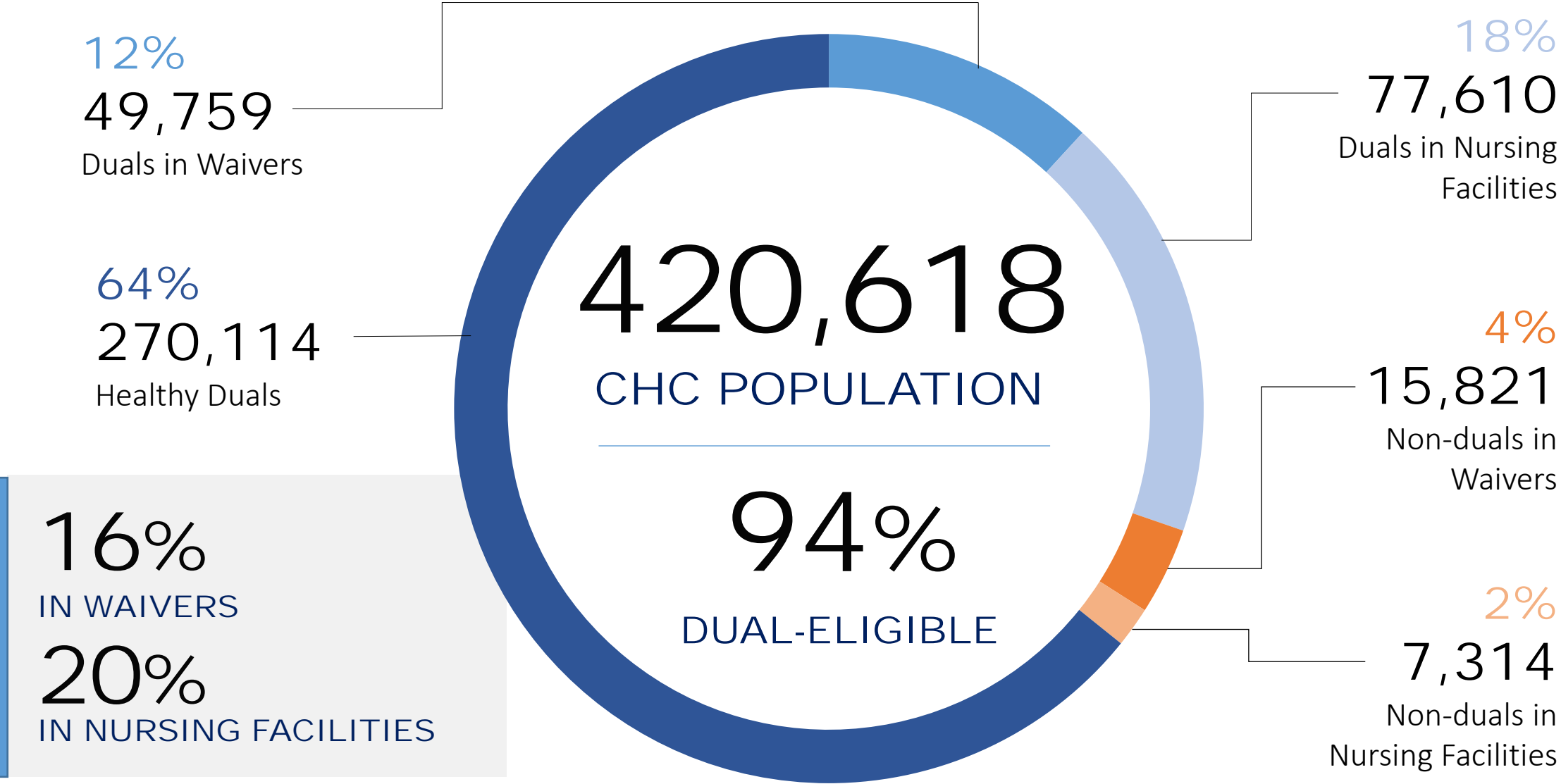
August 29, 2018

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).



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 DESIGN COMPONENTS

PENNSYLVANIA AS A NON-DUALS DEMONSTRATION STATE

- Relied on existing managed care experience and MLTSS experience from other states
- Solicited significant public input on program design
- Used an interdisciplinary project management approach for program design and implementation
- Initiated planning for quality evaluation throughout the program design phase

EXTENSIVE STAKEHOLDER ENGAGEMENT

- 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

INTERDISCIPLINARY PROJECT MANAGEMENT

- Included Workgroups for:
 - Information systems requirements:
 - Eligibility and enrollment
 - Encounters
 - Case management
 - Quality data collection
 - Procurement
 - Quality Assurance and Program Evaluation
 - Operations Readiness and Readiness Review
 - CMS authority
 - Rate setting
 - Communications

RELIANCE ON OTHER STATE EXPERIENCE

- CHC design took into consideration the MLTSS experience primarily of these states:
 - Tennessee
 - Texas
 - New York
 - New Jersey
 - Florida

RELIANCE ON PENNSYLVANIA'S MANAGED CARE AND HISTORICAL EXPERIENCE

- The CHC program used the contractual framework and carried through all of the physical health requirements of HealthChoices Program
- Components of Pennsylvania's large PACE (LIFE) program were also included in program design
- A behavioral health carve-out was maintained, similar to the Physical Health HealthChoices program
- The MIPPA agreement was used to support improved Medicare/Medicaid coordination
- Actuarial rate setting followed the cost of the services in the fee-for-service program

DHS SELECTED MCOs THROUGH A COMPETITIVE BIDDING PROCESS

- Publication of an RFP in March, 2016 with 14 proposals received
- Announcement of three selected offerors per zone in August, 2016
- The same three MCOs were selected in all five zones
- Procurement challenges extended into 2017 and required a delay in planned implementation



IMPLEMENTATION

- Outreach and Communication:
 - Provider Trainings
 - Broad Participant Outreach
 - Broad Participant Communications
- Implementation Engagement:
 - Contract Compliance
 - Readiness Review



QUALITY EVALUATION

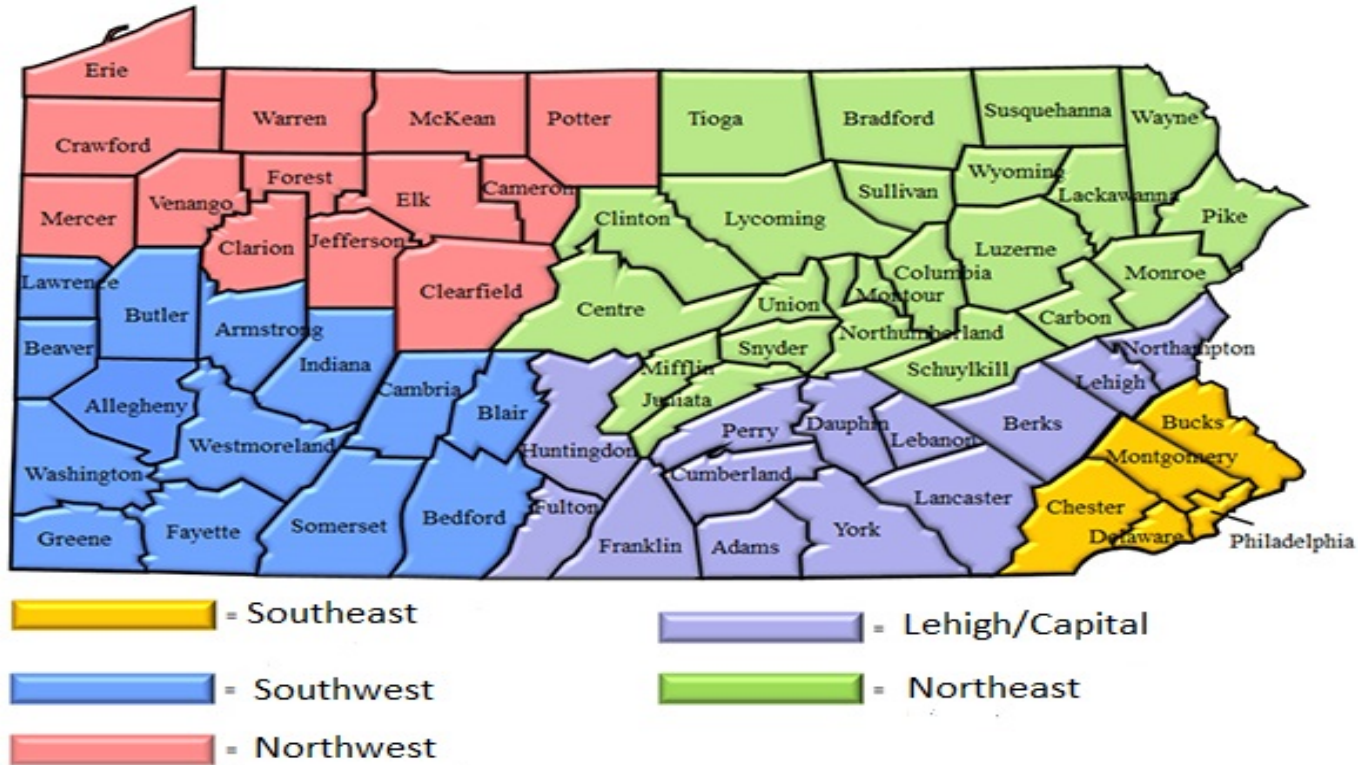
- Quality Pre-planning
- Vendor Review of Participant Experience
- Formal Quality Review through EQRO vendor and MCO Data Submission

ADDITIONAL CONSIDERATIONS

- Managed Care Final Rule
- Existing managed care configuration with Physical Health HealthChoices
- Behavioral health carve-out
- Population carve-outs
- Medicare Advantage enrollment penetration
- Staffing constraints
- Procurement process
- Continuity of care

REGIONAL PHASE IN

Five Geographic Zones



Phase One

January 1, 2018: Southwest Zone

Phase Two

January 1, 2019: Southeast Zone

Phase Three

January 1, 2020: Lehigh/Capital Zone
Northwest Zone; and Northeast Zone

Three managed care organizations supporting all five CHC zones:

- AmeriHealth Caritas (Keystone First)
- UPMC Community HealthChoices
- Pennsylvania Health and Wellness (Centene)



WHERE IS IT NOW?

SOUTHWEST IMPLEMENTATION

- Successfully implemented in the Southwest on January 1, 2018.
- Approximately 80,000 Participants were transitioned to the CHC program.
- Lessons Learned (so far) – EARLIER EVERYTHING
 - Earlier stakeholder engagement opportunities, trainings, OBRA reassessments, and data clean-up in HCSIS and SAMS
 - Enhanced communication regarding Medicare vs. CHC

SOUTHEAST IMPLEMENTATION

- Incorporation of Southwest implementation and launch lessons learned
- Comprehensive participant communication
- Robust readiness review
- Provider communication and training

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.

RESOURCE INFORMATION

CHC LISTSERV // STAY INFORMED: <http://listserv.dpw.state.pa.us/oltl-community-healthchoices.html>

COMMUNITY HEALTHCHOICES WEBSITE: www.healthchoices.pa.gov

MLTSS SUBMAAC WEBSITE:

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

EMAIL COMMENTS TO: RA-PWCHC@pa.gov

OLTL PROVIDER LINE: 1-800-932-0939

OLTL PARTICIPANT LINE: 1-800-757-5042

INDEPENDENT ENROLLMENT BROKER: 1-844-824-3655 or (TTY 1-833-254-0690)

or visit www.enrollchc.com



QUESTIONS



VIRGINIA MEDICAID COMMONWEALTH COORDINATED CARE PLUS

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Deputy Director of Complex Care
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The DMAS Mission



Superior Care

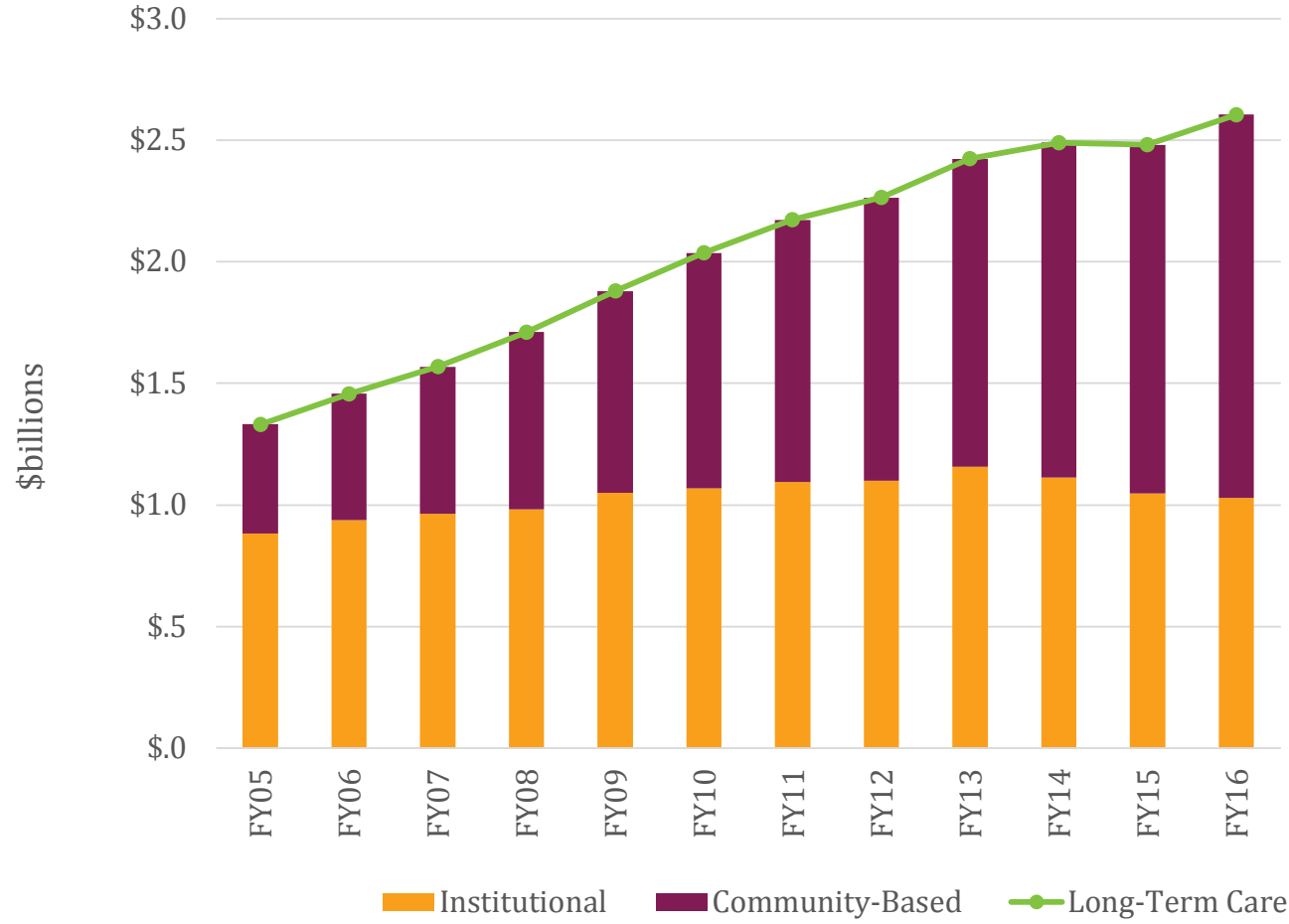


Cost Effective



Continuous Improvement

Rebalancing Long-Term Services



Average annual growth total fee for service Long Term Care services: 6%

Average annual growth Institutional services: 1%

Average annual growth Community-Based services: 12%

Proportion of Long Term Care services paid through Community-Based care has increased from 36% in FY05 to 61% in FY16

Financial Alignment Dual Demonstration

Commonwealth Coordinated Care (2014 – 2017)

- Three-way contract between Centers for Medicare and Medicaid Services, health plans and VA Medicaid
- Served approximately 30,000 dually eligible individuals across 5 regions of Virginia
- Participation was voluntary
- Integrated delivery model that included medical services, behavioral health services and long term services and supports (LTSS) provided by three health plans
- Care coordination and person centered care with a interdisciplinary team approach was main focus

Implementation & Operational Challenges

- Care coordinators had high caseloads
- Care coordinators were not in VA
- Eligibility file transfer problems with Info Crossing
- Not statewide
- Unable to add new populations
- Encounter data was not available
- FEA issues-reconciliation between plans and FEA
- Long continuity of care period (120 days)
- Health Risk Assessment elements were not aligned
- Too many services carved out

Response to Challenges

- Created Care Management Unit
- Established ratios for care coordination and mandated that care coordinators be in VA
- Developed internal encounter processing system
- FEA changes (Jan 1, 2019)
- Move to DSNP
- Changed continuity of care period to 90 days and then 30
- Established common elements in HRA
- Very few carved out services

Program Comparison

CCC Plus	CCC
Operates statewide in six regions	Operates in five of the six regions
Mandatory Enrollment	Optional Enrollment
Choice of up to 6 health plans	Choice of up to 3 health plans
Populations include duals/non-duals, children/adults, nursing facility, and individuals receiving services in the DMAS home and community based waivers	Populations include full dual adults (no children); including nursing facility and individuals receiving services in the Elderly and Disabled with Consumer Direction Waiver
The CCC Plus Medicaid plan coordinates Medicare benefits through the Member's Medicare plan. Members have the choice to select the CCC Plus health plan's companion dual special needs plan (D-SNP), or Medicare fee-for-service, or a different Medicare Advantage Plan	Coordination of Medicare benefits through same Medicare/Medicaid Plan (MMP)
Continuity of care period is 30 days (90 days initially)	Continuity of care period is 180 days
<i>Individuals enrolled in CCC transitioned to CCC Plus on Jan 1, 2018.</i>	

CCC Plus Populations



Approximately 210,000 individuals, including:

- Individuals age 65 and older
- Adults and children living with disabilities
- Individuals living in Nursing Facilities (NFs)
- Individuals in the CCC Plus Waiver (formerly the Tech Assisted Waiver and EDCD Waiver)
- Individuals in the 3 waivers serving the DD populations for their acute and primary services
- *CCC and Medallion 3 ABD populations transitioned to CCC Plus on 1/1/2018

CCC Plus Enrollment by Plan by Region

As of 8/3/2018

MCO	Tidewater	Central	Charlottes-ville	Roanoke Alleghany	Southwest	Northern VA/ Winchester	Total
Aetna	5,336	8,895	4,007	3,636	3,914	4,794	30,582
Anthem	13,879	16,199	5,398	4,833	3,501	16,534	60,344
Magellan	6,163	4,874	2,926	2,429	2,176	3,447	22,015
Optima	11,144	7,511	7,498	2,496	2,594	3,121	34,364
United	4,290	4,682	2,212	3,100	2,238	7,010	23,532
VA Premier	5,228	9,645	7,291	8,952	6,676	3,956	41,748
Total	46,040	51,806	29,332	25,446	21,099	38,862	212,585

Care Coordinator Role

Every member is assigned an MCO Care Coordinator who performs the following functions



Assess

- Conduct/coordinate Health Risk Assessment
- Identify barriers to optimal health



Plan

- Drive the development of person-centered, individualized care plan
- Include plan to support social determinants of health



Communicate

- Establish collaborative relationships that connect the enrollee, MCO, and providers



Coordinate

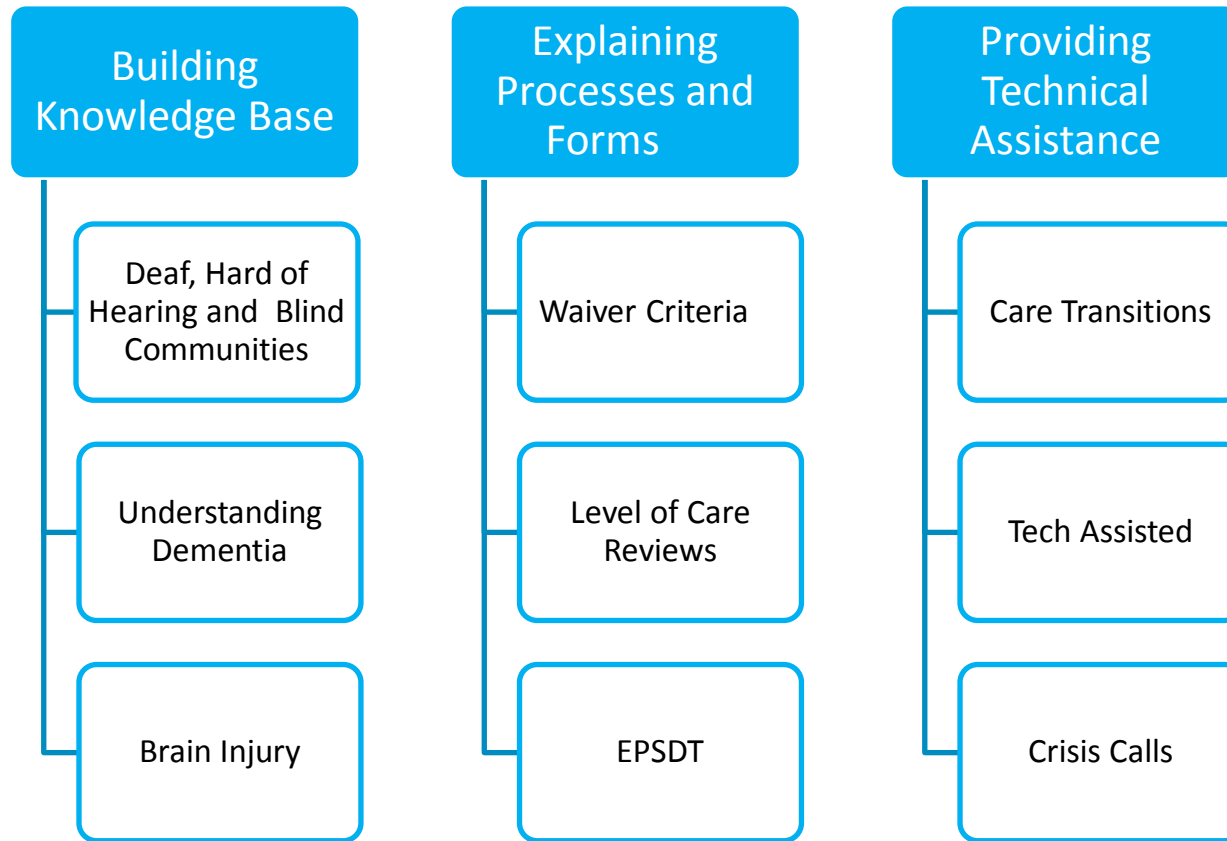
- Help navigate the health care system
- Coordinate team of health care professionals
- Support care transitions



Monitor

- Track progress towards goals
- Monitor status to avoid disruption in care
- Update plan of care

Care Coordination and Support



Care Coordinator Expectations

Virginia took a collaborative, hands-on approach with MCOs to establish clear expectations for care coordinators



Customized Training On-Site – DMAS Tech Waiver SMEs met with ALL health plans

- ✓ Education
- ✓ Clinical Case Reviews
- ✓ Joint Home Visits



Timely Information Sharing, Communication, & Training

- ✓ Weekly Training Calls on services, success stories, case reviews and scope of Care Coordinator role
- ✓ Coffee Talk Tuesdays dedicated to Live Q&A
- ✓ Specialized training based on identified learning needs – training series on EPSDT and understanding Dementia



Questions Answered Directly from Care Coordinators

- ✓ Dedicated Email box for their questions, concerns and requests for training
- ✓ Direct communication with DMAS Care Management Staff
- ✓ Email notices to growing group of registered Care Coordinators



Direct Issue Resolution Process with Care Coordinator Management and Clinical Leads

Recipe for Successful Implementation of CCC Plus

Phased Regional Implementation

Collaboration with
Stakeholders

Transparency

Clear
Expectations of
Health Plans

Readiness and
Systems Testing

Training

Stakeholder Engagement and Outreach



- ✓ Multiple provider work groups by discipline to streamline business processes
- ✓ 15 Provider and 16 Member Town Hall meetings statewide
- ✓ Provider webinars by discipline
- ✓ Member conference calls weekly; provider calls weekly (6 months into implementation)
- ✓ Over 100 outreach presentations to stakeholder groups
- ✓ Designated email inboxes to respond to questions

Dual Eligible Special Needs Plan

- Dual Eligible Special Needs Plan (D-SNPs) is a type of Medicare Advantage Plan limited to duals.
- D-SNPs cover Medicare Part A, B and prescription drug coverage under Part D.
- Duals can, but are not required to, enroll in the same health plan for Medicare and Medicaid benefits.
- VA created matching requirements in our Medicare and Medicaid contracts to support integrated care and care coordination efforts

Dual Eligible Special Needs Plans

Contract Elements - Coordination

Coordination of Care - General

Sharing of contact information

Participation in assessments, Interdisciplinary Care Teams, person centered planning

Share assessments

Timeliness – Plans to receive and utilize data

Timeliness – Member access to medically necessary services

Coordinate with BHSA

Coordination of Care - Transitions of Care

Share in timely manner member admission to and discharge from one level of care to another (ED, NF, etc.)

Participation in discharge planning

Timely access to medically necessary covered benefits

Establish tracking procedures to ensure compliance

Coordination of Benefits - Cost sharing

Sharing of contact information

Coordination of cost sharing and for CCC Plus paying crossover claims

Member and Provider Education

Must train providers on both CCC Plus and D-SNP benefits and services

CCC Plus to educate members on benefits of alignment

D-SNP Enrollment

Monthly CCC Plus and DSNP Alignment (as of June 2018)

MCO	Aligned	Unaligned	Percent Aligned	Total DSNP Enrollment
Aetna	211	6	97%	217
Anthem	3,558	336	91%	3,894
Optima	42	3	93%	45
United	2,371	5,028	32%	7,399
VA Premier	2,511	89	97%	2,600
Total	8,693	5,462	61%	14,155

What Have We Learned?

- **Strategic Planning is Essential**
 - Allow sufficient time for adequate planning and well coordinated transitions
- **Ongoing Stakeholder Input is Crucial**
 - Early and on-going stakeholder input is crucial to ensuring a smooth and efficient transition
- **Phased Implementation is Effective**
 - Use caution to not overload the system with too much too soon, especially for complex populations and services
- **Focus on Continuity of Care; “Do No Harm”**
 - Make certain the system is ready; i.e., health plans, providers, stakeholders, members, Medicaid Agency, are educated and ready
 - Ensure systems can connect, authorize, & pay claims
 - Respond to issues quickly