Volume 10

uds theADVOCATE
Your Resource To Understanding Pennsylvania's Community Health Choices

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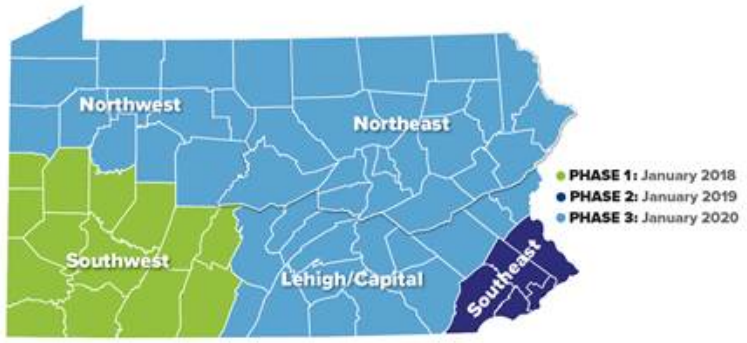
COMMUNITY HEALTH CHOICES UPDATE

What You Need to Know about the Statewide Transition Plan

COMMUNITY HEALTHCHOICES (CHC) is Pennsylvania's mandatory managed care program for individuals who are eligible for both Medicaid and Medicare (dual eligibles), older adults, and individuals with physical disabilities — serving more people in communities while giving them the opportunity to work, spend more time with their families, and experience an overall better quality of life.

When will Community HealthChoices be available?

Community HealthChoices is happening in phases across Pennsylvania. This program has already been introduced in the Southwest and Southeast regions, and will be implemented in the remainder of the state in January 2020.



AmeriHealth Caritas
Keystone First
pa health & wellness
UPMC Community HealthChoices

Continuity of Care

- Managed Care Organizations (insurance companies) are required to contract with all willing and qualified current waiver providers for 180 days after Community HealthChoices rolls out. The 180 day continuity of care requirement includes Service Coordination Entities.
- Participants may keep their existing waiver providers like UDS for the 180-day continuity of care period after Community HealthChoices begins.
- Participants with Medicaid may keep their existing physical health providers for 60 days after Community HealthChoices begins in your region. Participants with Medicare & Medicaid do not have to change because Medicare remains the primary insurance for your physician to bill.

How Does Community HealthChoices Work?

PARTICIPANTS

- Choose their Managed Care Insurance Carrier
- Should consider the provider network and additional services offered by each Managed Care

Department of Human Services

- Pays a per-member, per-month rate to Managed Care Orgs.
- Holds the Managed Care Organization accountable. This means you will have better quality services.

Managed Care Organizations

- Coordinates and manages physical health and Long Term Support Services for participants
- Works with Medicare and behavioral health MCOs to ensure coordinated care
- Develops a robust network of providers

WHAT FINANCIAL ELIGIBILITY POLICIES ARE CHANGING?

None. Existing financial eligibility rules still apply to all qualifying individuals. The County Assistance Offices (CAOs) will determine financial eligibility the same way they do today for all populations.

WHAT ARE THE INCOME AND RESOURCE LIMITS FOR LTSS?

For nursing facility services and home and community-based services (HCBS), an individual is income-eligible if gross monthly income is within 300 percent of the Federal Benefit Rate (FBR). A gross monthly income of $2,250 (2018) or less is considered income-eligible.
⇨An individual is resource-eligible if total countable resources are at or below $2,000, after a $6,000 standard automatic disregard from the total countable resources of the applicant.
⇨Examples of countable resources include assets such as cash (including checking and savings accounts), stocks, bonds, investments, and retirement plan assets.

CHC'S IMPACT ON MEDICARE SERVICES – What's Different:

• Dual eligible participants may keep their existing primary care physicians. However, a provider who bills frequently to Medicaid must enroll in Medicaid under federal guidance and the CHC-MCO will encourage the provider to become enrolled. If the provider bills Medicaid frequently but refuses to enroll, the CHC-MCO will work with the participant to find a new Medicaid enrolled provider.

• Each CHC-MCO is required to offer a companion Medicare managed care plan to its dually eligible participants. These plans are called Dual-Eligible Special Needs Plans (D-SNPs). Under CHC, participants will have an opportunity for a more coordinated approach to their care and may receive additional benefits by enrolling in their CHC-MCO's companion D-SNP.

• Once CHC is implemented, all Medicaid bills for participants will be submitted to the participant's CHC-MCO, including bills that are submitted after Medicare has denied or paid part of a claim.

• The CHC-MCO may not require prior authorization for services covered by Medicare. However, if service is denied by Medicare or there is a limit on the service of Medicare, the CHC-MCO may require prior authorization for the equivalent Medicaid service, as long as the CHC-MCO has a prior authorization policy that was approved by the state. Service coordinators will work with participants to coordinate prior authorization of services when needed.

GROWTH AT UNITED DISABILITIES SERVICES

UDS has seen significant participant growth in the last few months. Today we serve over 3,000 individuals. What has contributed to this great growth you ask?

- Quality
- Great Reputation
- Creating new positions
- Having a vision and working towards it
- The right people in the right positions – Service Coordinators
- Years of readiness preparation
- Leadership and coaching
- Everyone owning their practice

As we grow we are still very careful to hire people that can embrace the UDS culture. Our mission is real and it's worthy and draws the right people to want to work here.

*For more information call your Service Coordinator or visit www.dhs.pa.gov. For fast and efficient communication, please send your email to us at: ADVOCATE@udservices.org