Welcome: Stephanie Collins, Director of Programs & Mission Engagement, from Center in the Park welcomed attendees and described Center in the Park’s many programs and its rich history. Center in the Park is celebrating its 50th anniversary this year.

Panelists: Angela Lucente-Prokop, Senior Director of Operations, and Daniel Kleinmann, Community Outreach Specialist, from PA Health & Wellness; Jen Rogers, Director of Long Term Services and Supports, from Keystone First; Matt Jennings, Director of Product Development, UPMC Community HealthChoices; and Jennifer Hale, Executive Assistant for the Deputy Secretary of the Office of Long-Term Living (OLTL). Panel moderated by Kathy Cubit, CARIE’s Advocacy Manager. (Contact information provided at end of document.)

Introductions: Kathy introduced the panelists along with David Johnson as CARIE’s CHC Advocate. CARIE’s has a webpage dedicated to CHC resources at www.carie.org/ghc and just launched the CHC Grapevine, a CHC-focused e-newsletter. (Sign-up here.)

Managed Care Organization (MCO) Overview: (Each CHC-MCO plan representative provided a brief overview summarized here.)

**UPMC Community HealthChoices** - UPMC Community HealthChoices is owned by the University of Pittsburgh Medical Center (UPMC) and offers a variety of health plans with about 33,000 members in Southeast PA. They are new to providing Managed Long Term Services and Supports (MLTSS) coverage. UPMC plans to get rid of billable units for Service Coordination under CHC so service coordinators can focus more on the needs of participants. UPMC is also focused on Nursing Home Transition and are covering the cost of IDs for people who want to leave a nursing home. They are looking at social determinants of health and plan to partner with agencies that focus on food insecurity and other areas affecting social determinants of health. Since they are relatively new to this region, they are eager to hear from the community.

**Keystone First** - Keystone First is part of AmeriHealth Caritas and the leadership is the same for both companies. Under CHC, their plan is known as Keystone First in Southeast PA and AmeriHealth Caritas in the rest of the state. They are in the process of training current service coordinators to be prepared for the transition. For the 6 month continuity of care, participants’ services will be the same, but the procedures and computer system service coordinators use are changing. Since service coordination is a new service for nursing home residents, they plan to use Keystone-hired staff to provide service coordination for residents. Keystone First has person-care specialists who are trained like service coordinators but who are office-based so they are easily available by phone to answer participants’ questions as service coordinators are mostly field-based. While the Independent Enrollment Broker (IEB) determines program eligibility, they are screening Nursing Facility Ineligible (NFI) participants for potential eligibility for Long Term Services and Supports (LTSS). Any NFI participant found potentially eligible for LTSS will be referred to the IEB for enrollment.
**PA Health & Wellness** - While new to Pennsylvania, PA Health & Wellness (PHW) is part of a larger national company called Centene that provides Medicaid Long Term Services and Supports (LTSS) coverage in about 31 other states. PHW’s vision is improving the health of the community one person at a time. Their focus is being participant centered, holistic and engaging community partnerships including using locally-based service coordination services to offer participants choice and help ensure quality care. They have offices in Pittsburgh, Harrisburg and Philadelphia and are planning to open a claims center in Altoona. Their service coordinators have the support of behavioral health and clinical health specialists to help with complex cases. They have one toll free number for both participants and providers to use to help answer questions and a program coordination team that is committed to exceptional service to participants and providers.

**Questions and Answers:**

1. **When will participants receive their enrollment/welcome packets and ID cards from the individual Managed Care Organizations (MCOs)?**

   All Managed Care Organizations (MCOs) were awaiting enrollment data from OLTL. Keystone First received their first list of participants this week, so consumers should be receiving their cards and enrollment packets within the next couple of weeks. The other MCOs reiterated a similar timeline for the mailing of ID cards and packets. PA Health & Wellness added that once a participant is enrolled in their plan, they should get a call within 2 days, and a packet within 5.  

   *(Note from CARIE: Consumers will NOT receive their ID cards until the first week in January. Details in next CARIE CHC Grapevine.)*

2. **Will consumers be able to keep their current service coordinator?**

   Keystone First stated that they have provided, and will continue to provide, training to all service coordination entities (SCE). It is up to the individual SCE to determine how they want to assign service coordinators among the 3 MCOs. The experience from Southwest is that it is very difficult for a single service coordinator to be able to specialize in all 3 plans. Agencies have made internal decisions to assign specific service coordinators to specific plans for better efficiency.

   PA Health & Wellness (PHW) stated that exceptional health care and LTSS comes from a participant centered holistic approach and one that leverages community partnerships. PHW maintained all service coordination partnerships in the Southwest after the continuity of care period ended and does not require that service coordinators only work with their participants. PHW supports participant choice and a seamless transition. The goal is to avoid interruption in care. They are also working with current SCEs to be prepared for CHC start on January 1. They want to ensure contacts with participants are frequent and visits occur when planned.

   UPMC will not force anyone to switch their service coordinator during the continuity of care period, but they believe that the SCE will appoint service coordinators to work with one particular plan for the reasons already described. They are also providing training to SCEs about their policies and systems to help prevent any disruptions in care or payment.
3. Are the MCOs planning any direct marketing to consumers after January 1 for other insurance products they provide such as D-SNPs?

All 3 MCOs are required to have companion D-SNPs but the panelists were not able to respond if there were any D-SNP marketing plans. The 3 MCOs representatives were not able to answer as these are different products administered by other divisions at their companies. However, any CHC-MCO marketing must first be screened and approved by OLTL. All D-SNP marketing must be approved by the Department of Human Services (DHS) and if the marketing plans include any mention of CHC then OLTL also needs to approve before marketing can be implemented.

4. What is a D-SNP? What is the difference between an “aligned” and an “unaligned” D-SNP?

Medicare Special Needs Plans (SNPs) are special types of Medicare managed care plans. Like all Medicare managed care plans, private companies are paid by the federal government to administer Medicare benefits. D-SNP is an acronym meaning Dual Eligible Special Needs Plan and is an option for individuals enrolled in both Medicare and Medicaid (dually eligible individuals).

For the purposes of CHC, an aligned D-SNP is when the participant has a D-SNP plan and CHC plan from the same company. An unaligned D-SNP is when the participant has a D-SNP plan that is not affiliated with their CHC plan.

PA Health & Wellness stated Allwell is the plan name for their D-SNP.

5. For participants with a D-SNP, what happens when their CHC plan is from a different insurer than their D-SNP plan? How do these services get coordinated?

OLTL’s contract requires all D-SNPs and CHC-MCOs to coordinate care. This is a complex problem that has not fully been operationalized. The preferred approach is to have the participant’s CHC plan and D-SNP aligned to ensure optimal coordination of care. If the plans are unaligned, meaning that the consumer has a different MCO for CHC and D-SNP, then the 2 MCOs will need to share data and the 2 case managers from the different plans will need to work together to make sure that the participant’s needs were being met.

Keystone stated the CHC-MCOs now have data on who has what D-SNP and their case manager. They will work with them to align services.

PA Health & Wellness mentioned the staff that lead their D-SNP have been training SCEs on the benefit of aligned D-SNP/CHC plans.

UPMC added that CHC should not impact those with unaligned D-SNPs like Aetna.

(LIFE is an option for some 55 and older. LIFE is a fully integrated Medicare/Medicaid model of care.)
6. Should a CHC participant keep their current ACCESS card?

Yes. ACCESS cards will still be needed. However, for CHC participants with Medicare, their CHC-MCO ID card will be used for Medicare cost-sharing in lieu of their ACCESS card since the CHC plan will be responsible for paying Medicare out-of-pocket costs. Medicare providers will need to bill the participant’s CHC plan versus receiving payment from the state. Especially at the start of CHC, it is recommended that participants show both their ACCESS card and CHC plan ID card to Medicare providers. Medicare providers do not need to be in the CHC-MCO network to be paid.

There are two types of ACCESS cards. Both types will continue to be needed to access Medical Assistance Transportation Program (MATP) services. Those with SNAP (food stamp) benefits loaded on their cards will continue to use the card for this purpose.

7. Can the MCOs provide a concrete example of how the CHC and D-SNP plans work together for a dual eligible participant?

An example of when a participant is in aligned plans was provided. Case managers from the D-SNP and CHC-MCO work together to determine needs and services to ensure needs are met. When a service is offered by both plans, Medicare always pays first.

8. How will the MCOs ensure that home health agencies provide quality services?

UPMC said all CHC-MCOs are in agreement about carefully maintaining quality of care through evidence-based practices, utilization review, and data evaluation. UPMC has built a data system to review such items as the rate of hospital readmissions, number of falls, and missed shift reports. Since all CHC-MCOs are using the same billing platform, HHAeXchange, they will be able to monitor any overlap in billing among plans from staff and agencies.

Keystone emphasized that no providers will change during the continuity of care period unless the consumer desires a change. Keystone will do utilization reviews, evaluate the data, and look at “adverse events” as a gauge for quality performance.

PA Health & Wellness wants consumers to keep their chosen home health agency but will work with the agency or caregiver to improve the quality of care, if needed. PHW has a provider monitoring team, scopes of work and measures of performance to ensure quality standards are met or exceeded.

9. How will the MCOs protect against fraud or abuse by a family caregiver when hired to provide care under the person-directed model?

All MCOs emphasized accountability and structural safeguards to monitor care provided.

PA Health & Wellness provided an example of a caregiver who billed for 22 hours of care for one day. The case was sent to their fraud, waste and abuse team for investigation.
10. Are there reports around the number of contacts, or any other measures, to ensure coordination is happening between unaligned D-SNP and CHC plans?

OLTL has not developed a specific report that captures the contacts or other coordination measures between unaligned D-SNPs and CHC-MCOs at this time. It may be integrated into the CHC-MCOs’ performance reporting but not certain.

11. What is the difference between Medicaid and Medicare? What happens if choices are not made within the timeframes?

Medicare is a federal health insurance program where people are eligible based on paying into the Social Security system. People are eligible at age 65, or under 65 based on disability. Medicaid is a federal and state health insurance program. People are eligible based on income and resources. People with both Medicare and Medicaid are known as dual eligible beneficiaries. The state just assigned those who did not pick a CHC plan to a plan. A participant can change CHC plans at any time. If a participant selects a different plan than the one assigned by December 21, they will be enrolled in their selected plan by January 1. Consumers should consult CARIE or APPRISE for Medicare questions and help with plan selection, and the Independent Enrollment Broker (IEB) for CHC plan changes.

12. Will the MCOs be visiting Adult Day Centers for evaluation purposes?

All MCOs value Adult Day Centers as important components of socialization and support for participants. They want to ensure service coordinators are aware and receive training about adult day programs. PA Health & Wellness hopes to visit the centers.

13. Will there be changes impacting DME providers, such as Personal Emergency Response Systems (PERS)?

PERS services are not changing. PERS providers should make sure they have a contract with each CHC-MCO to get paid.

14. If the physician wants a plan of care that you disagree with, will that be resolved through physician to physician conversation, or a nurse? What are the qualifications for your nurses and other staff?

The CHC-MCOs have physicians that will discuss this as part of the entire person-centered care team. They are following the requirements of the OLTL agreement.

If the plan of care disagreement is related to Medicare, this would not apply to the CHC plans and would need to be appealed through the Medicare appeal process.

15. Are nutrition services covered in CHC plans?

Yes, nutritional counseling is provided under all CHC plans. Nutrition services providers should contact each CHC-MCO to sign a contract.
16. Will prescription coverage change? Can a participant continue with the medications they are currently receiving?

Since most participants have Medicare, prescription drug coverage will not change unless there are changes to a participant’s Medicare prescription drug coverage unrelated to CHC. For those who only have Medicaid coverage, they must use their CHC plan’s drug formulary. Each CHC plan has a consumer hotline to call with questions.

17. What is the State’s reason for changing Medicaid from a fee-for-service to a managed care model? How will this benefit consumers?

The state’s intention behind the change is to provide participating consumers with improved quality of care and coordination of services by integrating care with their physical health benefits and LTSS. The fee-for-service model creates barriers to integrating care while the managed care model provides some opportunity for MCOs to provide services that the consumer might otherwise not receive.

18. How do MCOs ensure that the care provided is culturally competent?

All MCOs emphasized the importance of culturally competent care. This is achieved through a variety of means: inclusion of interest groups, in-house training, peer-to-peer support, language lines, and interpreters. Each MCO is required to create a participant advisory council to make sure that various participant groups are appropriately represented.

Addendum

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