Community HealthChoices

Overview Module

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# CHC Overview

## Welcome

Welcome to an overview of Community HealthChoices.

## Course Objectives

The Department of Human Services (DHS) developed this online training to provide an overview of the Community HealthChoices program (CHC), the reasons for its implementation, enrollment in the program, and the benefits of CHC.

## Resources

Many resources and website links are mentioned in this module. To ensure they remain accurate, we have placed them in a separate document on this website.

Whenever a link or resource is available in the CHC Resources document, a bar will be displayed at the bottom of your screen.

# What Is Community HealthChoices

So, what is Community HealthChoices?

## What Is CHC?

CHC is an initiative that increases opportunities for older Pennsylvanians and people with disabilities to remain in their homes and increase their quality of life. CHC features the use of managed care organizations (MCOs) to coordinate physical healthcare and long-term services and supports that people need to stay at home and be fully engaged in the community.

## What are CHC’s goals?

The specific goals of the program are to:

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

## Who is included?

The program enrolls adults who are:

* Eligible for both Medicare and Medicaid, or
* Currently living in a nursing facility paid for by Medicaid, or
* Nursing facility clinically eligible (NFCE) and choosing not to enroll in the Living Independence for the Elderly (LIFE) program.

## What are the advantages of CHC?

Prior to CHC, individuals had to navigate a complex system to manage their health care, home care, and long-term service and support needs. CHC is a managed care program. This means that MCOs coordinate all healthcare, home care, and long-term services and supports (LTSS), such as doctor visits, specialist visits, therapies, homecare workers, home visits, transportation, behavioral health, and other services. Individuals and their families no longer need to navigate and coordinate all these pieces.

Please note that OLTL has alternative programs for individuals not eligible for CHC.

In addition to the benefits to individuals and families, a managed care approach also provides benefits to the Commonwealth. Prior to CHC, the Commonwealth had to review and assess the performance of thousands of organizations that provided these services. Under CHC, MCOs are accountable for health and long-term care outcomes. The Commonwealth assesses MCO performance.

The MCOs are accountable for how well the services are delivered. The primary reason that CHC was implemented was to provide better, more coordinated services so that individuals can live where they choose and be as engaged in their communities as they wish. MCOs are measured in terms of how well they meet the program’s goals and are expected to create better ways of serving Pennsylvanians.

## How does managed care work?

So, how does managed care work?

The Department of Human Services pays a per-member-per-month rate to the MCO. This is called a capitated rate. DHS then holds the MCO accountable for quality outcomes, efficiency, and effectiveness. The MCOs manage their members’ physical health and long-term care needs and coordinate with Medicare and with behavioral health organizations. Service providers—such as physicians, specialists, therapists, homecare, and home healthcare—contract with, are managed by, and are paid by the MCOs.

## Who are the MCOs?

There are three CHC managed care organizations in Pennsylvania:

* AmeriHealth Caritas, which goes by Keystone First in the Southeast,
* Pennsylvania Health & Wellness and
* UPMC Community HealthChoices.

All eligible individuals are asked to select one of the three MCOs when they enroll into CHC.

## When did this happen?

When did this happen?

Since January 2020, CHC has been fully implemented in Pennsylvania. The Southwest zone was first with an implementation date of January 2018, followed by the Southeast zone in January 2019, and finally by the Northwest, Northeast, and Lehigh/Capital zones in January 2020.

## What about the providers?

Each MCO is accountable for having an adequate network of providers. This means that MCOs must contract with enough providers to meet the needs of all program participants.

If you’d like to learn more about the individual MCOs, please check out the CHC Resources document. The resources document has contact information, emails, and websites for the MCOs.

Now check your understanding by answering these review questions.

## Lesson 1 Knowledge Check

1. True or False? The main goal of the program is to contain costs.

Please pause.

The correct answer is False. The goals include providing and enabling more community living opportunities, better care management, more innovation, and enhanced sustainability.

2. True or False? Each MCO is required to have an adequate network of providers. This means that MCOs must contract with all providers.

Please pause.

The correct answer is False. MCOs must contract with enough providers to meet the needs of all program participants.

# Who enrolls in Community HealthChoices?

So, who can enroll in Community HealthChoices?

## Who enrolls in CHC?

The following individuals can enroll in CHC.

Individuals who are 21 years old and over, are enrolled in CHC if they are:

* Dual-Eligible Participants – These are individuals enrolled in both Medicare and Medicaid (MA), or
* Participants needing LTSS – These are individuals who qualify for Medicaid long-term services and supports due to a need for the level of care provided by a nursing facility. Participants may receive Home and Community-Based Services (HCBS) at home or in the community or reside in a nursing facility. They may also be enrolled in both Medicare and Medicaid (MA).

Eligible individuals aged 55 and older may choose to enroll in CHC or enroll in the Living Independence for the Elderly (LIFE) program. The LIFE program features a managed care approach as well.

## LIFE

The LIFE program is a capitated managed care model that fully integrates comprehensive LTSS, behavioral health, and physical health services to Medicare or Medicaid participants.

To be eligible for LIFE, you must:

* Be age 55 or older,
* Nursing facility clinically eligible,
* Meet the financial requirements as determined by your local County Assistance Office or be able to privately pay,
* Live in an area served by LIFE, and
* Be able to be served safely in the community.

The program is based on a national program called the Program of All-Inclusive Care for the Elderly. The program focuses on individuals living independently in their home and communities for as long as possible. LIFE is an option for eligible individuals alongside CHC.

## Who is not eligible?

Individuals are NOT eligible for CHC if they are:

* Receiving LTSS in the OBRA waiver and are not nursing facility clinically eligible,
* A person with an intellectual or developmental disability who is receiving services beyond supports coordination through the Department of Human Services’ Office of Developmental Programs, or
* A resident in a state-operated nursing facility, including the state veterans’ homes.

## How do individuals enroll?

So, how do individuals enroll in CHC? Pennsylvania has an Independent Enrollment Broker (IEB) for its LTSS programs. The IEB is an independent organization that walks people through enrolling in CHC and selecting an MCO. The IEB follows up with each person, provides options, and helps with the decision-making process by asking about current providers and preferences.

For example, if a participant really likes their current primary care doctor, they would select an MCO that has that provider in its network. Please note that dual eligible participants can keep their Medicare providers regardless of whether they are in the MCO network or enrolled in Medicaid. Remember, the MCO manages all services and supports by contracting with doctors, therapists, specialists, homecare, and other healthcare providers. The IEB helps participants select an MCO that best fits their needs and preferences in healthcare and homecare providers.

## What if participants need more information?

What if participants need more information? Educational materials are available on the DHS HealthChoices website. Call Centers are available for questions throughout the process. Contact information is listed in the CHC Resources document.

## Applying for CHC

Individuals applying for CHC are enrolled in a similar manner to enrolling in current federal and State waiver programs. The IEB coordinates the enrollment activities, which are:

* The physician diagnosis and certification,
* The functional ability and eligibility determination, and
* A financial eligibility assessment.

## Applying for LTSS

Individuals applying for LTSS, like waiver services or nursing facility care, are given the choice of MCOs during the enrollment process. If they do not choose an MCO, one is assigned to them. Please note that participants can change their selected MCO at any time.

## Not Applying for LTSS

For individuals not applying for LTSS, the MCO is selected after CHC eligibility is determined. Participants are covered by the fee-for-service program until they are enrolled with their MCO.

## Transitioning from HealthChoices

For participants transitioning from a HealthChoices MCO to a CHC-MCO, services must continue for 60 days to prevent any interruption in services.

## Transitioning between MCOs

If a participant chooses to transfer to a different CHC-MCO, the receiving CHC-MCO must continue to provide the previously authorized services for 60 days or until a comprehensive needs assessment has been completed and a person-centered service plan has been developed and implemented, whichever date is earlier. This is known as the continuity of care period.

## Transitioning from HealthChoices or between MCOs

In both cases, the participant can continue with their current providers, even if the provider is not in the receiving MCOs network.

Now check your understanding by answering these review questions.

## Lesson 2 Knowledge Check

1. True or False? People who are eligible for CHC do not choose their MCO.

Please pause.

The correct answer is False. Eligible participants will be asked to select from three MCOs. If a participant does not select an MCO, they will be assigned to one. Participants can change MCOs at any time if they discover that another is a better fit for them.

2. True or False? Information for individuals who are enrolling in CHC is available only from the IEB.

Please pause.

The correct answer is False. Individuals enrolling in CHC will receive information from the IEB. Additional educational materials are available on the DHS HealthChoices website.

# What is covered?

You may be wondering about what is covered in CHC? Let’s talk about that next.

## What is covered?

All CHC participants receive the physical health benefits in the Adult Benefit Package. These include services like doctor visits, laboratory tests, and hospital stays.

For participants who are not receiving LTSS, MCOs are required to do a health screen within 90 days to understand their participant’s needs. This provides a mechanism to determine if people require additional services to stay healthy and remain at home.

For participants who qualify for MA LTSS (nursing facility residents and waiver participants), there are several services and activities that are added or expanded in CHC.

Behavioral health services are provided through the existing HealthChoices behavioral health MCOs. The CHC-MCO will work with the behavioral health MCO to ensure that all services are coordinated.

## What about service coordination?

A notable aspect of CHC is how services are planned and coordinated. MCOs use service coordinators (SCs) to visit people in the program to review current services and assess their needs, strengths, goals, and preferences. The discussion includes healthcare, home care, community engagement, and housing.

People no longer need to work with multiple organizations. One organization, the MCO, helps people to improve their health, maintain their independence, and enhance their quality of life while living in the setting of their choice.

If a CHC participant currently lives in a nursing facility and wants to move back into the community, the MCO manages the process, which includes finding affordable, accessible housing, and coordinating in-home services.

If a CHC participant is living at home and wants to start working again, their SC can assist them in finding and keeping a job.

## What about a care plan?

An essential piece of the managed care approach is that CHC participants have a care management plan that focuses on coordinating their physical and behavioral health services, including:

* Active chronic conditions,
* Health services,
* Veteran’s services,
* Medicare services, and
* Other services.

Participants with LTSS needs have a person-centered service plan. These plans include a care management plan focused on their physical and behavioral health needs with an LTSS plan. Person-centered service plans are developed with participants and their person-centered planning team.

## What does the planning team do?

The team, representing all aspects of care and support, works together with the CHC participant to come up with the best approach to ALL needs and goals, not just the ones in their specialty. This is good for program participants because it saves time and energy . . . one plan with one team instead of multiple appointments and planning sessions with different organizations.

Team planning ensures that “specialty areas” are well coordinated. It also helps everyone who supports the participant to understand the person and their situation so that they can provide better quality service.

Finally, a managed care approach is good for families and caregivers. Instead of needing to work with multiple care managers, SCs, home care providers, doctors, and specialists, families can work with one team to plan, coordinate, and monitor services. That one team is held accountable for how well the participant progresses. If things change with the person, there is one call to make. If things do not go as expected, there is one organization accountable to improve the situation.

## What else is included?

In addition to a more integrated approach to planning, coordinating, and monitoring services, the MCOs have more flexibility in providing a broader range of services. MCOs are required to honor program participants’ wishes in terms of living in the least restrictive setting. People can choose to live in the community. It is the responsibility of the MCO to line up the services needed to do that.

The availability of affordable, accessible housing can be a barrier for people who do not choose to live in a nursing facility. MCO planning teams are responsible for working with individuals and housing services so that housing situations do not force a facility placement. MCOs also work with people to adapt housing to their needs and to deal with pest eradication and other housing support services.

In some cases, behavioral health issues become a barrier to living in the community. People may need help with individual or social conflicts, family issues, or other communication and interpersonal issues to remain independent. In addition to services covered by the behavioral health MCOs, CHC provides counseling services, cognitive rehabilitation, and behavior therapy services. The managed care approach seeks to identify and address barriers to people living successfully in the community.

Please note that behavioral health services are available to everyone enrolled in CHC, including individuals that reside in a nursing facility.

Another added benefit of the managed care approach relates to changes in where people live and receive care. Prior to CHC, transitioning out of a nursing facility could involve nursing facility staff, a nursing home transition provider, the IEB and a service coordination provider. With this number of organizations (working under separate billing structures), there is a greater risk of gaps or interruptions in service. With managed care, the MCO handles all aspects of an individual moving among settings and is accountable for the success of the move. Individuals and families work with one organization and one planning team.

In summary, MCOs make it easier for program participants and their families to plan and receive services. A managed care approach also provides a central point of accountability for the services provided and funds invested.

Now check your understanding by answering these review questions.

## Lesson 3 Knowledge Check

1. True or False? Participants enrolled in CHC have access to behavioral health services.

Please pause.

The correct answer is True. All participants in CHC have access to behavioral health services and are automatically enrolled in a behavioral health MCO when enrolled in CHC.

2. True or False? People lose their choice of providers under a managed care system.

Please pause.

The correct answer is False. Participants in CHC choose their direct service providers. Choice is a federally-mandated and state-supported function. Participants choose from providers who have contracted with MCOs in their region. MCOs must have an adequate network of providers.

3. True or False? CHC participants living in a nursing facility and planning to stay, do not need to select an MCO.

Please pause.

The correct answer is False. The MCO provides additional support and services. Residents are strongly encouraged to select an MCO. If they do not, one will be assigned to them.

## FAQs

Hopefully, we've helped you better understand what Community HealthChoices is and how it improves the quality of healthcare and home care. But you may still have some questions.

Please read some frequently asked questions about Community HealthChoices.

#### Who is eligible for Community HealthChoices (CHC)?

Individuals are eligible for CHC if they are 21 years or older and:

* Are dually eligible for Medicare and Medicaid; OR
* Qualify for Medicaid long-term services and supports because they need the level of care provided by a nursing facility.

Individuals are not eligible for CHC if they:

* Are a person with an intellectual or developmental disability (ID/DD) who is receiving services beyond supports coordination through DHS’ Office of Developmental Programs; OR
* Are a resident in a state-operated nursing facility, including the state veterans’ homes.

If individuals are eligible for, and select, the Living Independence for the Elderly (LIFE) program, they are not enrolled in CHC unless they specifically ask to be moved to CHC.

#### How does an individual apply for Community HealthChoices (CHC)?

Call the Independent Enrollment Broker (IEB) or use the enrollment website.

If eligible, the IEB will talk to individuals about the Community HealthChoices Managed Care Organization (CHC-MCO) options and enroll them in the program. They will have a choice of available CHC-MCOs (or the Living Independence for the Elderly (LIFE) program, where available) and will receive counseling to help make a decision about which CHC-MCO best meets their needs.

Contact information for the IEB can be found in the CHC Resources document.

#### Do individuals have a choice of Community HealthChoices Managed Care Organizations (CHC-MCOs)?

Yes. Individuals are encouraged to choose their Managed Care Organization (MCO). The MCOs to choose from are AmeriHealth Caritas (which is known as Keystone First in the southeast), PA Health & Wellness, and UPMC Community HealthChoices.

#### What if an individual doesn't choose a Community HealthChoices Managed Care Organization (CHC-MCO)?

If they do not choose a CHC-MCO, they will be automatically assigned to a plan. Individuals can change their Managed Care Organization (MCO) at any time.

#### What services will Community HealthChoices (CHC) cover?

CHC covers the same physical and behavioral health benefits that are currently available through the Medicaid Adult Benefit Package.

Additionally, if an individual is assessed to need the level of care provided in a nursing facility but chooses to remain at home or in the community, CHC provides a number of Home and Community-Based Services.

Links for the CHC Fact Sheet and the Adult Benefits Package can be found in the CHC Resources document.

#### How does the individual receive behavioral health services through CHC?

Behavioral health services are offered through the existing network of behavioral health managed care organizations (BH-MCOs). Individuals do not need to select a BH-MCO. It is automatically included through enrollment in CHC.

Community HealthChoices Managed Care Organizations (CHC-MCOs) and BH-MCOs will work together to ensure everyone gets the coordinated services they need.

#### Does Community HealthChoices (CHC) cover assisted living facilities and personal care homes?

CHC does not pay for room and board in assisted living facilities or personal care homes. However, they are allowable settings in which to receive certain Home and Community-Based Services covered by CHC.

#### If an individual receives services through the Department of Aging’s OPTIONS program, will they still be able to get services through OPTIONS?

If an individual is a dual eligible but does not qualify for Medicaid long-term services and supports, they can continue to get long-term services and supports through the OPTIONS program. They will get their Medicaid healthcare services through Community HealthChoices (CHC) and their long-term services and supports through OPTIONS. If they become clinically eligible for nursing facility level of care, they may apply to get their long-term services and supports through CHC.

#### Who is responsible for service coordination in Community HealthChoices (CHC)?

The Community HealthChoices Managed Care Organization (CHC-MCO) is responsible for assuring that service coordination is provided. This is done either through contracts with service coordination entities or through internal CHC-MCO service coordination staff.

#### How will the Commonwealth ensure that service coordinators include all needed services in the service plan?

Service coordinators work with participants and their supports to ensure the participant’s person-centered service plan meets their needs. Participants must be provided all needed, covered services.

There are many ways that the Commonwealth monitors this requirement:

* Monitoring of reduction in service plan authorizations,
* Requiring service plan change reports from the Community HealthChoices Managed Care Organizations (CHC-MCOs),
* Review of all grievances and appeals from participants,
* Review of Fair Hearings decisions,
* Review of encounter data and plan comparisons,
* Monitoring how often participants leave a CHC-MCO, and
* Conducting participant surveys.

# Conclusion

Thank you for taking the time to learn about Community HealthChoices and how it is providing choice, promoting independence, and making it easier for Pennsylvanians to live in their communities.

For more information about Community HealthChoices, and to keep current with events in your area, go to www.dhs.pa.gov/healthchoices or call the helpline.

# Congratulations

Congratulations! You have completed this module.

If you have read the contents of the entire module, register your completion of this module by going to the appropriate webpage.

If you are an enrolled provider, go to this [webpage](https://oltl-provider.deringconsulting.com/chc-overview-completion/).

If you are not an enrolled provider, go to this [webpage](https://oltl-provider.deringconsulting.com/not-enrolled-chc-overview-completion/).