Community HealthChoices

WHO IS SERVED BY CHC?

COMMUNITY HEALTHCHOICES (CHC) is Pennsylvania's mandatory managed care program for individuals who are eligible for both Medical Assistance 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 implemented, CHC will improve services for hundreds of thousands of Pennsylvanians.

THE CHC POPULATION IS ESSENTIALLY TWO POPULATIONS:

1. DUAL-ELIGIBLE PARTICIPANTS

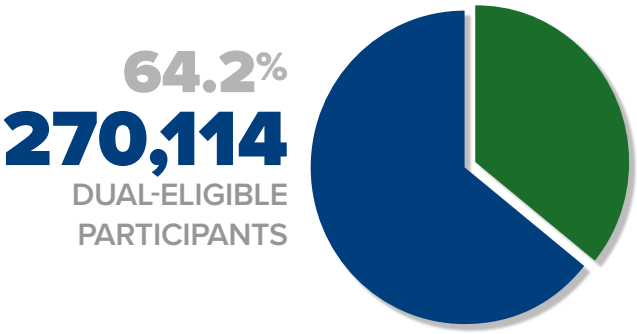
Individuals enrolled in both Medicare and Medical Assistance.

2. PARTICIPANTS NEEDING LTSS SERVICES

Individuals who qualify for Medical Assistance long-term services and supports (LTSS) due to a need for the level of care provided by a nursing facility. Participants receiving LTSS at home through a waiver program or reside in a nursing facility. They may also be enrolled in both Medicare and Medical Assistance.

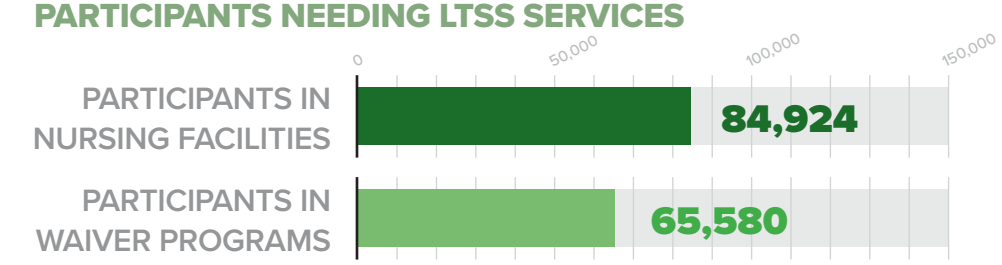
420,618

TOTAL CHC POPULATION



64.2%
270,114
DUAL-ELIGIBLE PARTICIPANTS

35.8%
150,504
PARTICIPANTS NEEDING LTSS SERVICES



QUESTIONS? CALL THE CHC PROVIDER HOTLINE AT **1-800-932-0939.**

BENEFITS FOR DUAL-ELIGIBLE PARTICIPANTS

Must be on both Medicare and Medical Assistance.

Adult Benefit Package
Physical and behavioral health

**Behavioral health benefits are provided through the existing behavioral health managed care organizations.*

Screenings
- Managed care organizations (MCOs) must do a health screening for all dual-eligibles within 90 days of the start date of CHC in the zone.

Care management plans
- The MCO must offer dual-eligibles the ability to have a care management plan.

Comprehensive needs assessment
- The MCO must conduct a comprehensive needs assessment when the participant requests one, self-identifies as needing LTSS, or if the MCO or independent enrollment broker identifies the need for one.

Medicare and behavioral health coordination
- The MCO must coordinate with Medicare and the behavioral health MCOs to provide participants with comprehensive and coordinated services.

DEFINITIONS

- **Care Management Plan**
  A written plan that identifies and addresses how the participant's physical, cognitive, and behavioral health care needs will be managed.
- **Comprehensive Needs Assessment**
  A tool that assesses a participant's physical and behavioral health, as well as social, psychosocial, environmental, caregiver, LTSS and other needs. Preferences, goals, housing, and informal supports are also assessed.
- **Person-Centered Service Plan (PCSP)**
  A written plan that addresses how the participant's physical, cognitive, and behavioral health needs will be managed, and how the participant's LTSS services will be coordinated. This includes both a care management plan and LTSS plan.

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BENEFITS FOR PARTICIPANTS NEEDING LTSS SERVICES

Adult Benefit Package
Physical and behavioral health

LTSS Benefit Package

Comprehensive needs assessment
- The MCO must conduct a comprehensive needs assessment for all LTSS participants annually.
- MCOs will also conduct an assessment if a trigger event occurs, such as a significant health care event or change in supports or settings.

Person-centered service plan (PCSP)
- All LTSS participants will have a PCSP developed by the participant, their service coordinator and their person-centered planning team.
- The plan must be completed and updated no more than 30 days after the last comprehensive needs assessment.

Service coordination
- The primary objective of service coordination is to support participants to identify needs, assure appropriate service delivery, and coordination with all other services including Medicare and behavioral health.
- All LTSS participants will have a service coordinator.

** Behavioral health benefits are provided through the existing behavioral health managed care organizations. This is new for Aging Waiver participants and nursing facility residents.*

• **QUESTIONS?** CALL THE CHC PROVIDER HOTLINE AT **1-800-932-0939.**

REVISED: APRIL 2018

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ADULT BENEFIT PACKAGE

THE FOLLOWING PHYSICAL AND BEHAVIORAL HEALTH BENEFITS ARE AVAILABLE TO **ALL CHC PARTICIPANTS.** BEHAVIORAL HEALTH BENEFITS WILL BE PROVIDED BY THE BEHAVIORAL HEALTH MANAGED CARE ORGANIZATIONS.

- Certified registered nurse practitioner services
- Chiropractic services
- Clinic services
- Crisis services
- Contact lenses (limited to individuals with aphakia)
- Dental care services
- Durable medical equipment
- Emergency room/ ambulance services
- Eyeglass frames (limited to individuals with aphakia)
- Eyeglass lenses (limited to individuals with aphakia)
- Family planning services and supplies
- Federally qualified health center services/rural health clinic services
- Home health services
- Hospice services
- ICF/IID and ICF/ORC (requires an institutional level of care)
- Inpatient hospital services
- Laboratory services
- Maternity (physician, certified nurse, midwives, birth centers)
- Medical supplies
- Mobile mental health treatment
- Nonemergency Transportation (only to and from MA-covered services)
- Nursing facility services
- Nutritional supplements
- Optometrist services
- Outpatient hospital services
- Peer support services
- Physician services
- Podiatrist services
- Prescription drugs
- Primary care provider services
- Prosthetics and orthotics (Orthopedic shoes and hearing aids are not covered)
- Radiology services (i.e., x-rays, MRIs, CTs)
- Renal dialysis services
- Targeted case management services (behavioral health only, limited to individuals with SMI only; other than behavioral health; limited to individuals identified in the target group)
- Therapy (physical, occupational, speech; habilitative and rehabilitative; only when provided by a hospital, outpatient clinic or home health provider)
- Tobacco cessation

HELPFUL TIPS

- **Be sure to carry your ACCESS card with you at all times.** When receiving health care services, show all your insurance cards, including your ACCESS card.

- **If you need a new ACCESS card,** call 1-877-395-8930. In Philadelphia, call 1-215-560-7226.

CHC managed care organizations may provide more services than those required by the CHC program.

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LONG-TERM SERVICES AND SUPPORTS BENEFIT GUIDE

THE FOLLOWING BENEFITS ARE AVAILABLE TO PARTICIPANTS WHO ARE DETERMINED TO BE **NURSING FACILITY CLINICALLY ELIGIBLE AND RECEIVE MEDICAL ASSISTANCE LONG-TERM SERVICES AND SUPPORTS THROUGH A HOME- AND COMMUNITY-BASED WAIVER OR RESIDE IN A NURSING FACILITY.** THESE ARE IN ADDITION TO THE PHYSICAL HEALTH BENEFITS IN THE ADULT BENEFIT PACKAGE.

- Adult daily living services
- Assistive technology
- Behavior therapy
- Benefits counseling
- Career assessment
- Cognitive rehabilitation therapy
- Community integration
- Community transition services
- Counseling
- Employment skills development
- Financial management services
- Home adaptations
- Home delivered meals
- Home health aide
- Home health – nursing
- Job coaching
- Job finding
- Non-medical transportation
- Nutritional counseling
- Participant-directed community supports
- Participant-directed goods and services
- Personal assistance services
- Personal emergency response system (PERS)
- Pest eradication
- Residential habilitation
- Respite
- Service coordination (including information and assistance in support of participant direction. Service coordination is furnished as a distinct activity to waiver participants as an administrative activity)
- Structured day habilitation
- TeleCare
- Vehicle modifications

EXTENDED STATE PLAN SERVICES

- Home health – physical, occupational, and speech and language therapies
- Specialized medical equipment and supplies

CHC managed care organizations may provide more services than those required by the CHC program.

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WHAT IS COMMUNITY HEALTHCHOICES?

COMMUNITY HEALTHCHOICES (CHC) is Pennsylvania's mandatory managed care program for dually eligible individuals and individuals with physical disabilities — serving more people in communities, giving them the opportunity to work, spend more time with their families, and experience an overall better quality of life. CHC has improved services for hundreds of thousands of Pennsylvanians.

CHC was developed to: 1. Enhance access to and improve coordination of medical care and; 2. Create a person-driven, long-term support system in which people have choice, control, and access to a full array of quality services that provide independence, health, and quality of life. Long-term services and supports (LTSS) help eligible individuals to perform daily activities in their homes such as bathing, dressing, preparing meals, and administering medications.

Who will be enrolled in CHC?

Individuals will be enrolled in CHC if they are 21 years old or over and are:

- Receiving both Medicare and Medicaid; or
- Receiving LTSS in the Attendant Care, Independence, or Aging waivers; or
- Receiving services in the OBRA waiver *AND* determined nursing facility clinically eligible; or
- Receiving care in a nursing home paid for by Medicaid.
- An Act 150 participant who is dually eligible for Medicare and Medicaid.

Individuals are ***NOT*** eligible for CHC if they are:

- Receiving LTSS in the OBRA waiver and are NOT nursing facility clinically eligible; OR
- An Act 150 program participant, who is not dually eligible for Medicare and Medicaid; OR
- A person with an intellectual or developmental disability who is receiving services through the Department of Human Services' Office of Developmental Programs; OR
- A resident in a state-operated nursing facility, including the state veterans' homes.

Individuals who already participate in a Living Independence for the Elderly (LIFE) program can remain in their LIFE program and will not be moved into CHC unless they specifically ask to change. Anyone who is enrolled in CHC who would prefer to participate in a LIFE program and qualifies to participate in LIFE will be free to do so.

What does CHC cover?

CHC covers the same physical health benefits that are part of the Medicaid Adult Benefit Package today. If you are eligible for LTSS, you can also get all services now available in waivers offered by the Office of Long-Term Living. With one exception, CHC will replace these waiver programs.

The OBRA waiver will continue to exist for those 18-20 year olds who qualify for Medicaid LTSS and for those who have a severe developmental physical disability and need an Intermediate Care Facility/Other Related Conditions (ICF/ORC) level of care.

Behavioral health services are not a part of CHC. The CHC MCO must coordinate care with their members' HealthChoices Behavioral Health MCOs.

CHC MCOs have the same responsibility for coordination of members' Medicare coverage.

Will individuals have a choice of CHC MCOs?

YES. Each CHC participant may choose his or her MCO. The MCOs are AmeriHealth Caritas, PA Health & Wellness, and UPMC Community HealthChoices.

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WILL COMMUNITY HEALTHCHOICES AFFECT MY MEDICARE?

COMMUNITY HEALTHCHOICES (CHC) WILL NOT CHANGE YOUR MEDICARE COVERAGE.

Medicare is a federal health insurance program. It is your primary insurance and covers most of your health care services, including prescription drugs.

You also have another insurance called Medicaid, known as Medical Assistance in Pennsylvania. Medical Assistance is your secondary coverage that you receive through the ACCESS card. It helps with Medicare costs and gives you additional benefits. When you have both Medicare and Medical Assistance, you are a dual-eligible.

CHC will only change how you receive your Medical Assistance coverage. When you become enrolled in CHC, you will choose one of three CHC plans: AmeriHealth Caritas, PA Health & Wellness, and UPMC Community HealthChoices. Starting in January 2020, the CHC plan you choose will become your new Medical Assistance coverage.

Questions? Visit **www.HealthChoices.pa.gov** or call the CHC Participants Hotline at **800-757-5042.**

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HOW WILL COMMUNITY HEALTHCHOICES AFFECT MY MEDICARE?

WHAT DO I NEED TO DO?

Pick a CHC plan.
Call 1-844-824-3655 or enroll online at www.enrollchc.com. If you do not select a plan, you will be auto-enrolled into a plan starting January 1. You can change your plan at any time after CHC begins.

CAN I SEE OTHER MEDICAL PROVIDERS THAT ARE NOT IN MY CHC PLAN NETWORK?

Yes. — When you receive any Medicare-covered services, your CHC plan will pay for any cost sharing. For services that are not covered by Medicare (such as dental care or eye exams), you will likely need to use a provider that is in your CHC plan's network. Your CHC plan can help you figure out what services Medicare covers.

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DOES MY PRIMARY CARE PRACTITIONER (PCP) HAVE TO BE IN THE CHC NETWORK?

No. — If you have a Medicare PCP that is not in your CHC plan's network, you can keep this doctor.

DO I NEED TO MAKE CHANGES TO MY MEDICARE?

You may choose to change your Medicare, but you do not have to.
One of the goals of CHC is to have your Medicare and Medical Assistance work better together. No matter what Medicare coverage you have, your CHC plan will work with your Medicare and providers. If you would like to make any changes to your Medicare coverage, an APPRISE counselor can help you. Call 1-800-783-7067. If you do not know what Medicare coverage you have, please call APPRISE at 1-800-783-7067 or the Pennsylvania Health Law Project at 1-800-274-3258.

DATE: JANUARY 2020

Questions? Visit **www.HealthChoices.pa.gov** or call the CHC Participants Hotline at **833-735-4416.**

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APPLICATION GUIDE

IF YOU NEED LONG-TERM SERVICES AND SUPPORTS

HOW DO I APPLY?	**Phone:** Call our Independent Enrollment Broker (IEB) at 1-877-550-4227. They will be available to help you apply for long-term services and supports (LTSS) through the Community HealthChoices (CHC) program; **Online:** www.compass.state.pa.gov
HOW DO I KNOW IF I QUALIFY?	To be eligible for LTSS, you must meet the financial eligibility and need criteria. The IEB will schedule an in-person assessment for you, which is done in your home, in a hospital, or in a nursing facility — wherever you are. This will determine if you need LTSS. The IEB will also help you complete a Medicaid application, which is sent to the county assistance office (CAO). A caseworker from the CAO might contact you for additional information if they have questions about your financial information. Once those things are completed, you will be notified by the department if you qualify for Medicaid services.
HOW DO I CHOOSE MY MANAGED CARE ORGANIZATION (CHC-MCO)?	When you meet with the IEB, they will talk to you about the CHC plan options in your area. You should think about which health care and long-term services providers participate with the CHC plan, as well as any additional services that the CHC plan might offer. If you do not make a selection, a CHC plan will be assigned to you. If you want to change your CHC plan, you may do so at any time.
WHEN DOES MY COVERAGE BEGIN?	Your coverage with the CHC plan begins on the date you are determined eligible. The CHC plan will contact you to select a service coordinator. The service coordinator will work with you to develop a service plan and assist you with finding service providers. If you have medical expenses prior to the date that your CHC plan coverage starts, these expenses might be covered.

THE LIFE PROGRAM // If you are at least 55 years old, you may also be eligible for the Living Independence For the Elderly (LIFE) program, which is a voluntary managed care program different from CHC. You must be nursing facility clinically eligible, financially eligible for Medical Assistance, reside in an area served by a LIFE provider, and be able to live safely at home or in the community. Call 1-844-824-3655 or go to www.palifeprograms.org/locate-a-life-program for more information.

Community HealthChoices

APPLICATION GUIDE

IF YOU DO NOT NEED LONG-TERM SERVICES AND SUPPORTS

HOW DO I APPLY?	**Online:** www.compass.state.pa.gov; **Phone:** 1-866-550-4355; **Mail:** Applications can be found at www.HealthChoices.pa.gov; or **In person:** visit a county assistance office.
HOW DO I KNOW IF I QUALIFY?	In order to qualify for CHC, you must be on Medicare and financially eligible. The county assistance office will determine if you are financially eligible and might contact you for additional information if they have questions. Once those things are completed, the commonwealth will let you know if you quality. Then you will need to work with our IEB to choose which CHC plan you will get coverage from.
HOW DO I CHOOSE MY MANAGED CARE ORGANIZATION (CHC-MCO)?	The IEB will send you information about selecting a CHC plan. You should think about health care providers who participate in each network and any additional services that the CHC plan might offer. If you do not make a selection, a CHC plan will be assigned to you. If you want to change your CHC plan, you may do that at any time.
WHEN DOES MY COVERAGE BEGIN?	Once approved, your Medicaid coverage will begin on the date of your application. The IEB will send you a letter that states the date that your CHC plan coverage will begin. If you have prior medical expenses, these expenses might be covered.

DATE: FEBRUARY 2020